

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00501 4</u>
<b>C-514</b> <b>BIRTH NO.</b> <u>70-00138</u>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <u>BABY GIRL CAMPBELL "B"</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>1/3/70</u> <u>6:57</u> A.M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MD. HOSPITAL</u> <u>38</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY _____ <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2613 Miles Ave -</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/2/70</u>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE</b> (In years last birthday) <u>14</u>
<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA Baltimore MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>Robert Campbell</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Farley Patricia</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Chart</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>14 1/2 hrs</u>
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>MD -</u>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (1) (this hospital) attended the deceased from <u>birth</u> 19<u>70</u> to <u>death</u> 19<u>70</u> that (1) (we) last saw the deceased alive on <u>1/3/70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Dr. Leffer MD</u>		<b>23B. DATE SIGNED</b> <u>1/3/70</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Dr. Leffer MD</u>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <u>1-15-70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 16 1970</u>		<b>25B. NAME OF REGISTRAR</b> <u>John E. Felt</u>		<b>25C. FUNERAL DIRECTOR</b> <u>MORTUARY SERVICE - BCHD</u>





1. NAME OF DECEASED (Type or Print) Woodrow <del>Greager</del> TAYLOR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M. 1 1 70 5:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR ROOM NO. 33 Church Home and Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 1 70 5:50 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 52 50		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER Edison Hotel, North Gay Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Werner U. Spitz* M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 1/2/70  
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 1-12-70	24C. NAME OF CEMETERY	24D. LOCATION (City, State)
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHO

Letter from M.E.'s office

3-23-70 M.H.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DONALD ASPER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 9, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 9, 1970 1:05 P. M.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1401	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday) 48	11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1423 Johns St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 428X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Focal interstitial myocardial fibrosis  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-10-70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-13-70		24C. NAME OF CEMETERY OR CREMATOR Annapolis	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCD	

ACADEMY BOND

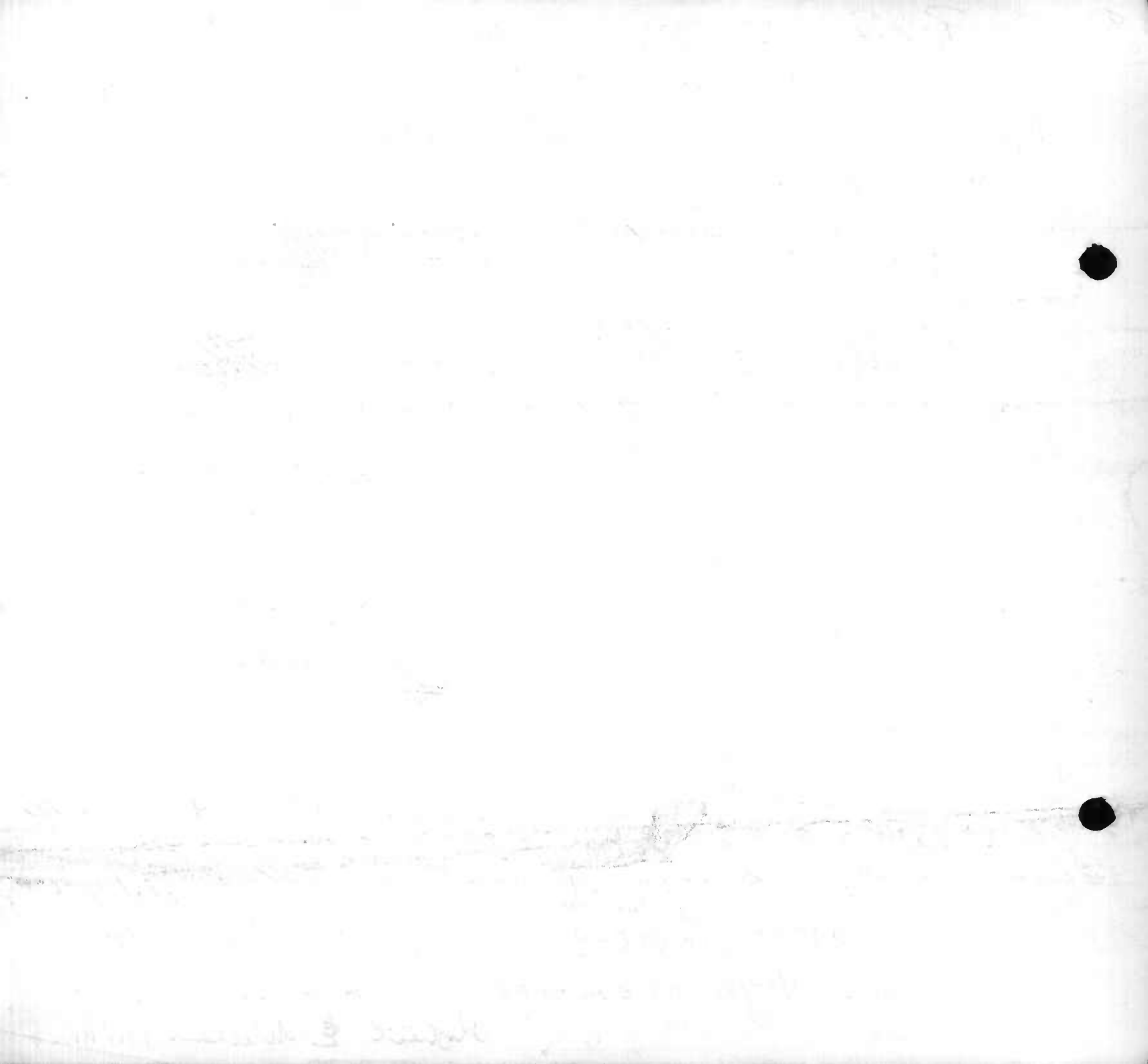
VALLEY PAPER CO.

U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
70 00504					REG. NO. 70 00504				
BIRTH NO. <b>R-420</b>					1. NAME OF DECEASED (Type or Print) <b>WILLIAM ROLES</b>				
2. DATE AND HOUR OF DEATH <b>1-9-70 7:00 PM.</b>					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>806</b>					5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b>				
6. CITY OR TOWN <b>BALTIMORE</b>					7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
8. STREET AND NUMBER <b>1721 N. BOND ST.</b>									
9. SEX <b>MALE</b>		10. RACE <b>COLORED</b>		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH <b>9-18-91</b>		13. AGE (In years last birthday) <b>78</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. KIND OF BUSINESS OR INDUSTRY		16. BIRTHPLACE (State or foreign country) <b>md</b>		17. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
18. FATHER'S NAME <b>William E. Roles</b>					19. MOTHER'S MAIDEN NAME <b>Isabella Thomas</b>				
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>					21. SOCIAL SECURITY NO. <b>218 32 4332</b>		22. INFORMANT <b>Family</b>		
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.91</b>					24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Heart failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>MI Diabetes</b> (C) _____				
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____				
27. DATE OF OPERATION <b>0</b>		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) <b>—</b>		30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>					
34. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		36. HOW DID INJURY OCCUR?					
37. I certify that (I) (this hospital) attended the deceased from <b>12/18/69</b> to <b>1/9</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
38. SIGNATURE <b>James E. Muller MD</b>					39. ATTENDING PHYSICIAN Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		40. DATE SIGNED <b>1/1/70</b>		
41. PHYSICIAN'S NAME (Type) <b>JAMES E. MULLER</b>					42. ADDRESS <b>1531 E. Monument St</b>				
43. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		44. DATE <b>1/14/70</b>		45. NAME OF CEMETERY OR CREMATORY <b>MT CALNARY</b>		46. LOCATION (City, town, or county) (State) <b>A. A. COUNTY, MD</b>			
47. DATE REC'D BY HEALTH DEPT. <b>16 1970</b>		48. NAME OF REGISTRAR <b>Robert E. Taylor</b>		49. FUNERAL DIRECTOR <b>Robert E. Taylor</b>		50. ADDRESS <b>1701 Bond St</b>			





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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00505	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Spencer, Reuben</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">1-13-70. 18:24 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">33</span> <span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">701</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">901 N. Kenwood Avenue 21205</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12/16/93</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">76</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Greenberry Spencer</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>ADDRESS</b>	
<b>18. I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> <span style="font-size: 1.2em;">Respiratory Insufficiency</span> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">(B) Possible Pulmonary Embolus</span> DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">(C) Metastatic Adenocarcinoma</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">30 mins</span>  <span style="font-size: 1.2em;">30 mins</span>  <span style="font-size: 1.2em;">Months</span>
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">11-12-70</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Metastatic Adenocarcinoma</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No.</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1-8</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">1-13-</span> 19 <span style="font-size: 1.2em;">70</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1-13</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Ronald C. Elkins M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1-13-70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Ronald C. Elkins, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial Jan 19-70 Balto. National</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">Jan 19-70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Balto. National</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore</span>		<b>24E. ADDRESS</b> <span style="font-size: 1.2em;">1701 N. Bond St</span>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 16 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Williams</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Robert E. Williams</span>	

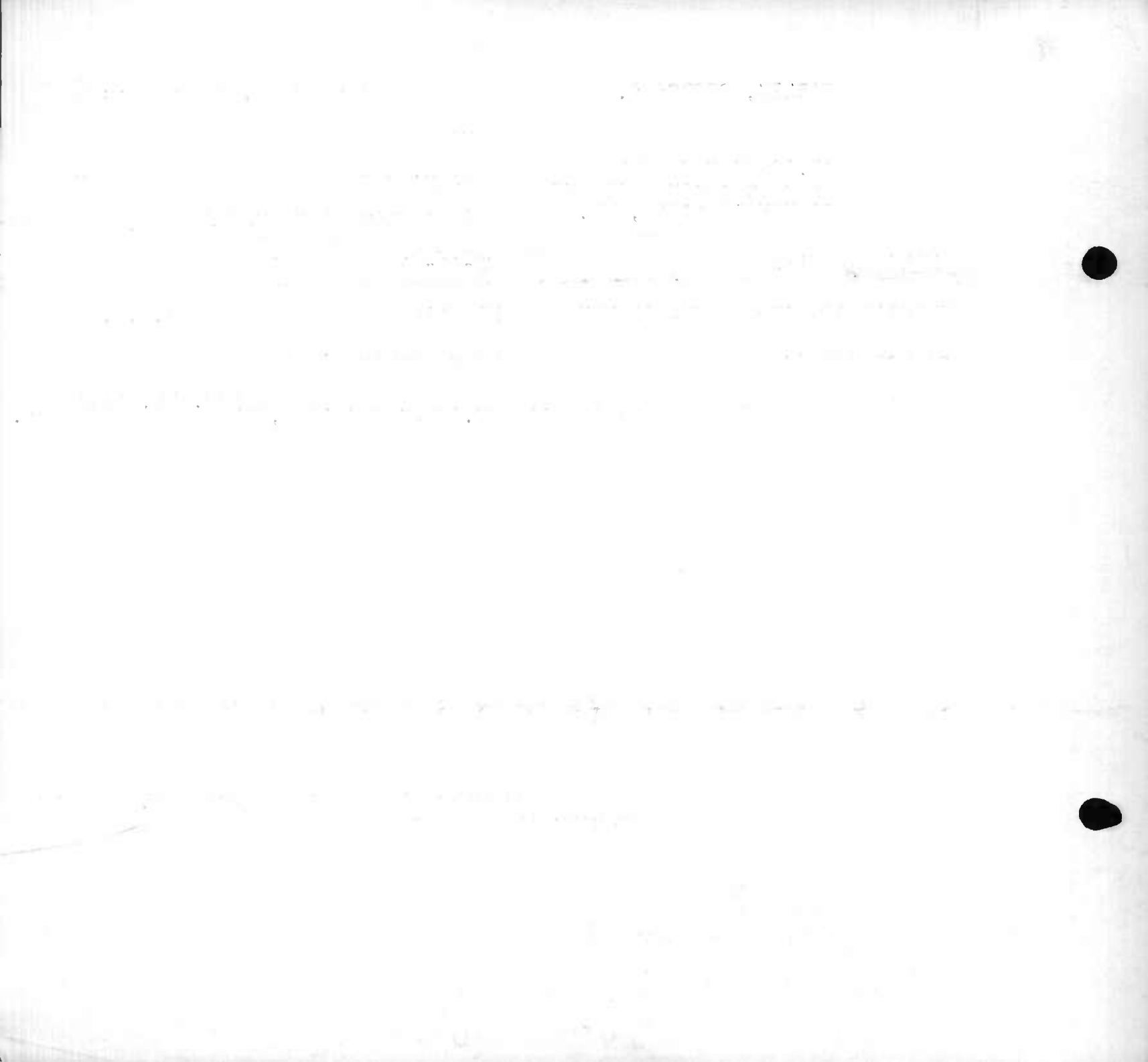




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
70 00506		70 00506					
BIRTH NO.		2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FARLEY, GEORGE A.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40		ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.		MARYLAND Balto.co.		5300	
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
MALE		WHITE		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		E. STREET AND NUMBER			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		07-13-87		6601 FREDERICK AVENUE			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
FUNERAL DIRECTOR		FUNERAL HOME		82		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				U.S.A.	
GEORGE FARLEY		MARY (MCMAHON) FARLEY					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		219328811		BALTO. MD. 21229		ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
412.4 I		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Hrs.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		Years.			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 04 1970 to JANUARY 14 1970 that (I) (we) last saw the deceased alive on JANUARY 14 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED					
		1/14/1970					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
ADNAN M. SONMEZ		1011 Frederick Rd. Balto. Md. 21228					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-19-70		Cathedral Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 16 1970		E. J. B. G. O. D.		J. J. G. O. D.		J. J. G. O. D.	



## 70 00507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00507

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LORENZO CRAWFORD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 14, 1970 1:45 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-12-1929</b>		10. AGE (in years lost birthday) <b>40</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disable</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>217-24-2805</b>	
18. INFORMANT <b>Mr. Alfred Robinson</b>		ADDRESS <b>1616 W. Franklin Street</b>	
19. <b>571.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gastrointestinal Hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Fatty Metamorphosis of Liver</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/14/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-16-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>R. E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

ACADEMIC REPORT

FOR JOURNAL

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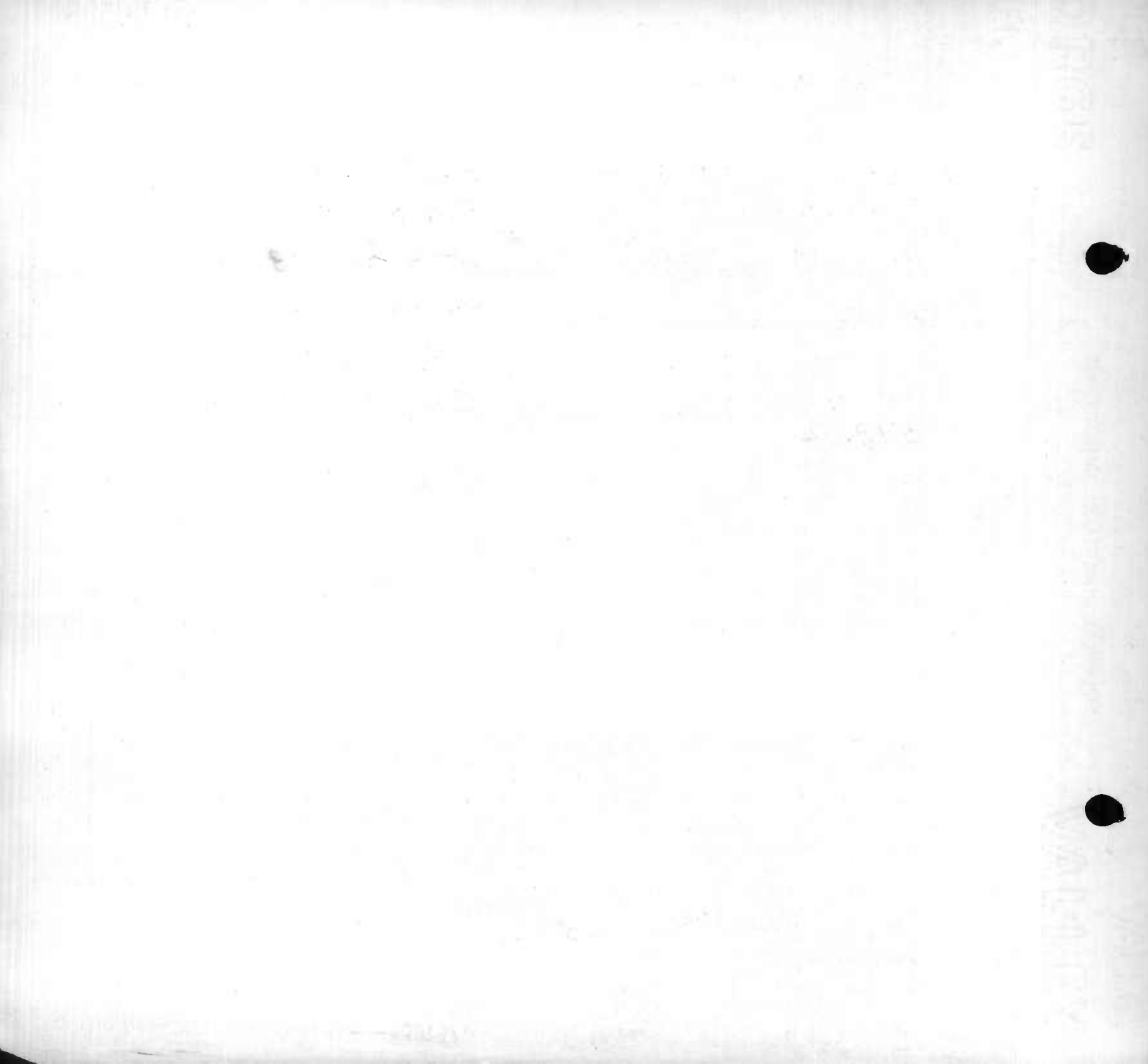
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1-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00508	
70 00508		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RANDE A. Z</b>	
2. DATE AND HOUR OF DEATH <b>1. 15. 70</b>		<b>9.05 a. m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2844</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b> <b>6730 Ashburton St</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>816 KEVIN Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-3-36</b>
9. AGE (In years lost birthday) <b>43</b>		10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disable</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Roosevelt Lowe</b>		14. MOTHER'S MAIDEN NAME <b>Ada Rundle</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 2/28/52 2/19/54</b>		16. SOCIAL SECURITY NO. <b>244-22-3213</b>	
17. INFORMANT <b>Chart Mamie Chapman</b>		ADDRESS <b>3702 Harlen</b>	
18. <b>519.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Longestine cardiac failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic obstructive air disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (C) <b>Embolus</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Embolus</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1. 14</b> <b>1970</b> to <b>1. 15</b> <b>1970</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>1. 15</b> <b>1970</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>P. GNANES M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>1. 15. 70</b>
23C. PHYSICIAN'S NAME (Type) <b>P. GNANES MD</b>		23D. ADDRESS <b>Lutheran Hosp. Ashburton St - Balto.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-19-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	25C. FUNERAL DIRECTOR <b>Horizon Edgett F.H.</b> ADDRESS <b>1701 Laurens St</b>	



M-200

## BALTIMORE CITY HEALTH DEPARTMENT

70 00509

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

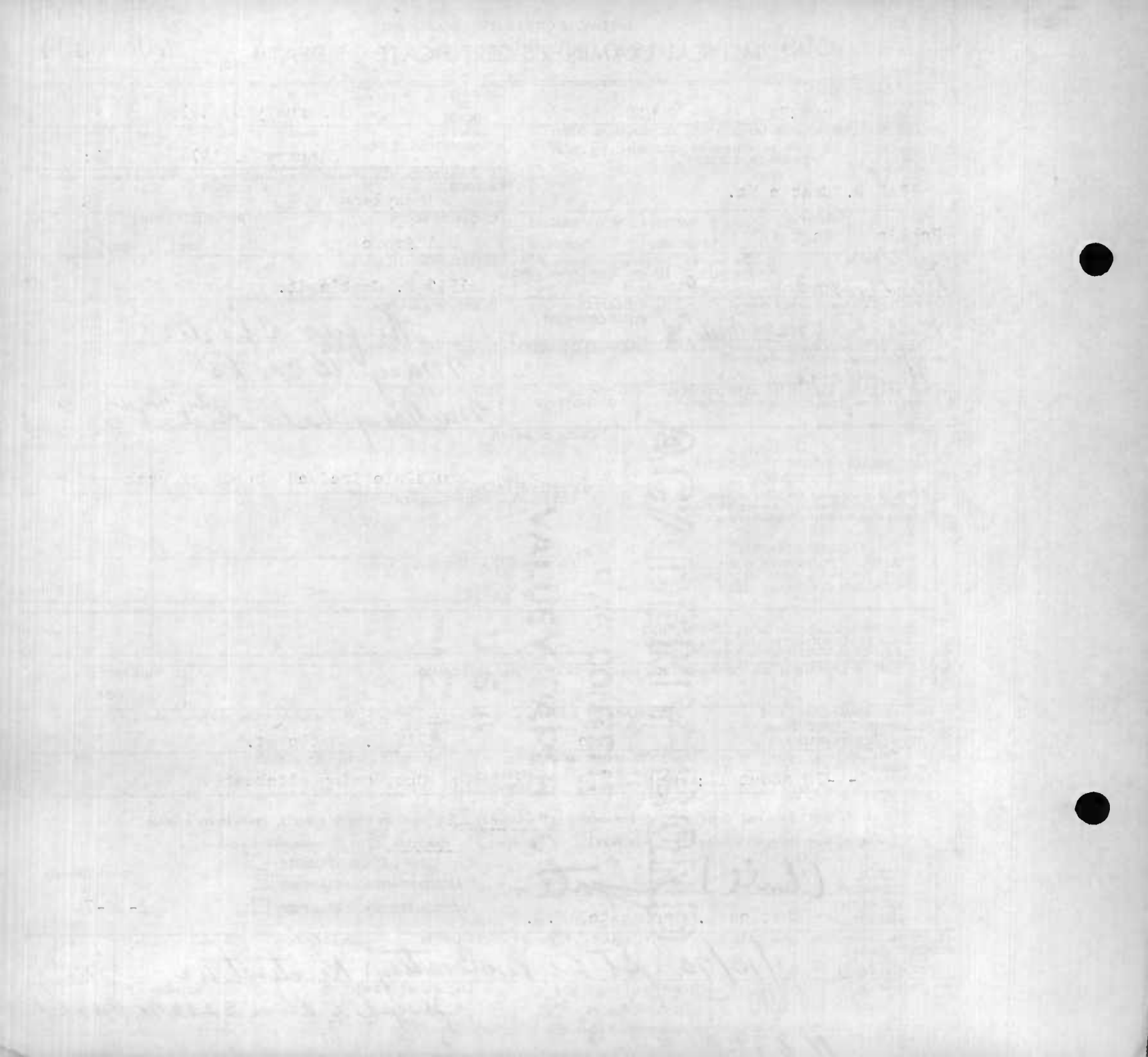
REG. NO.

70 00509

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCIS MACK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 9, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1712 N. Castle St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 9, 1970 12:40 P.M.</b>	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec. 19, 1943</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>20</b>		E. STREET AND NUMBER <b>1712 N. Castle St.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cornwall, Ontario, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>Rufus Charles</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Brooks</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Mary Charles Rustenstrom, Md.</b>	
19. CAUSE OF DEATH <b>E966 XI</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple incised wounds of neck DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1712 N. Castle St.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1-9-70 about 11:00 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Cut during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-10-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Luke's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Rustenstrom Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>		ADDRESS <b>2222 W. North Ave.</b>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-2621

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 00510

BIRTH NO. 65-0464570 00510

1. NAME OF DECEASED  
(Type or Print)

Rogers, Cynthia

2. DATE AND HOUR OF DEATH

1/10/70

5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1813 Kavanaugh Street

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3/1/65

9. AGE (In years last birthday)

4

10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Daniel Jacobs

14. MOTHER'S MAIDEN NAME

Evelyn Rogers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Evelyn Rogers 1813 Kavanaugh St

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/4/70 to 1/10/70 that (I) (we) last saw the deceased alive on 1/10/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Jay W. Pettegrew,

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/10/70

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

B

24B. DATE

1/15/70

24C. NAME of CEMETERY or CREMATORY

mt Calvary C

24D. LOCATION

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 16 1970

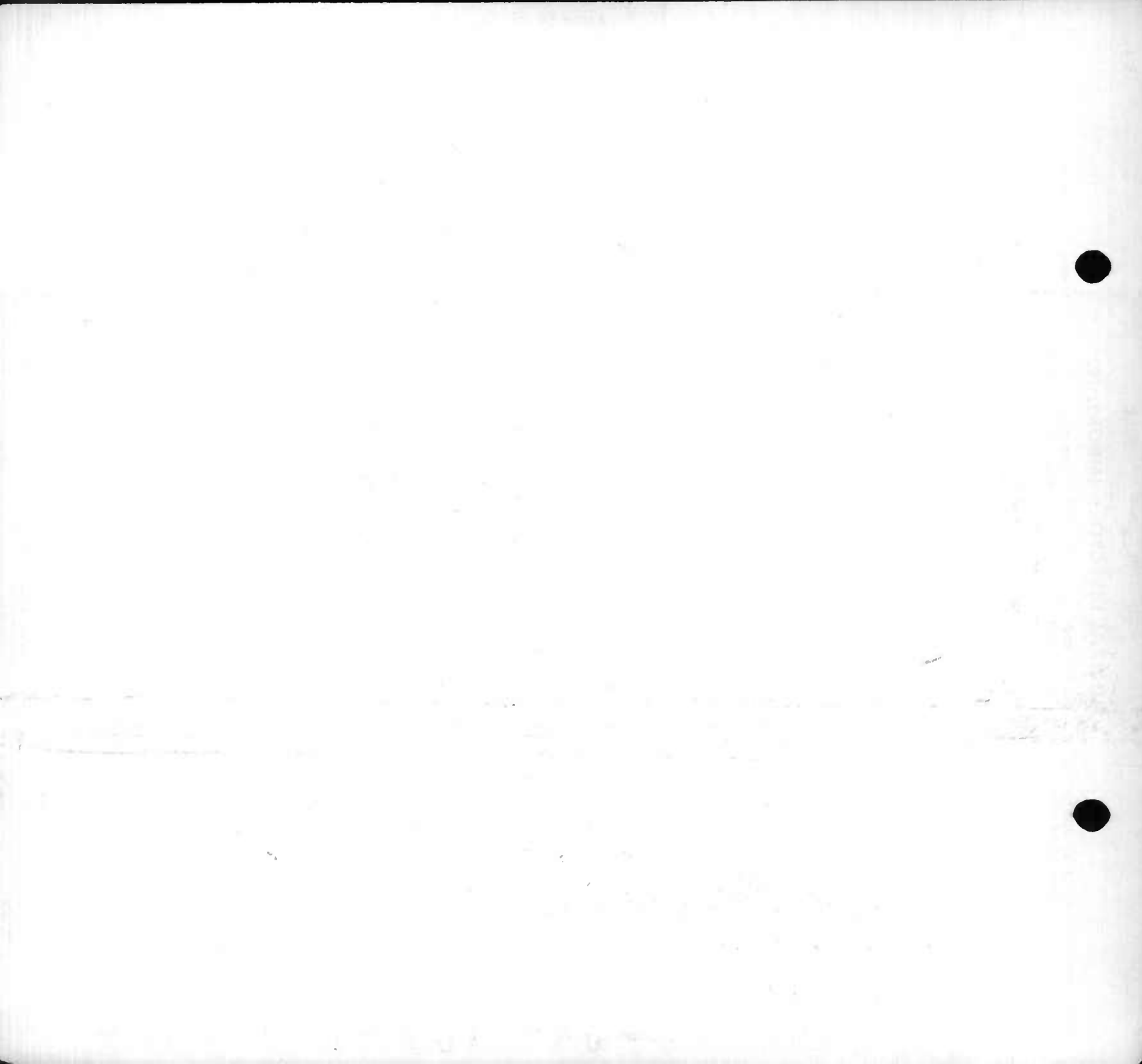
25B. NAME OF REGISTRAR

Robert E. Jacoby, Jr.

25C. FUNERAL DIRECTOR

2222 n north

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00511	
BIRTH NO. 70 00511		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HENDERSON, JAMES		2. DATE AND HOUR OF DEATH Jan 15 1970 3:15 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 1606 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2700 W. MOSHER STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-20	9. AGE (In years last birthday) 49	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North CAROLINA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JAMES HENDERSON		14. MOTHER'S MAIDEN NAME JULIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JULIA BURRELL 2700 Mosher ST	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GRAM NEGATIVE SEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GRAM NEGATIVE PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: PRE-HEPATIC COMA w/ ASPIRATION (C) 8-10 days			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/26 1969 to Jan 15 1970 that (I) (we) last saw the deceased alive on Jan 15 1970 and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE N. F. Adkinson, Jr.		23B. DATE SIGNED Jan 15, 1970		23C. PHYSICIAN'S NAME (Type) N. F. ADKINSON, JR., M. D.	
23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. A. County, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph L. Roberts		25D. ADDRESS 1304 N. Central Ave	



54-01-75 csk

P-620

70 00512

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO. 70 00512

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Theol Phears		1/13/70 5 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
31		Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		Maryland 1301	
5. SEX		6. RACE		C. CITY OR TOWN	
Female		Negro		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6-19-11		58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Norman Gray				Rosie Bowen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
430.914 018.9					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1/12/69		infected shunt		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/12/69 to 1/13 1970 that (I) (we) last saw the deceased alive on 1/13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mehdi Sarkarati, M.D.				1/13/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Mehdi Sarkarati, M.D.		Baltimore City Hospital 4940 Eastern Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-17-70		Arbutus Mem Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 16 1970		Robert E. Sabin, M.D.		On 5 March 928 E. North Ave.	

10/2/5

1  
M-265

## BALTIMORE CITY HEALTH DEPARTMENT

70 00513

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00513

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DORA McCORMICK

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

SINAI HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

7:20 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-23-2029

10. AGE (In years  
last birthday) 40If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2610 Quantico Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Campbell

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cashier

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Thelma Alston

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-26-2081

18. INFORMANT

Mrs Estelle Massenburg

ADDRESS

2133 Homewood Ave.

19.

412.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-22-70

24C. NAME of CEMETERY or CREMATORY

National Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 16 1970

25B. NAME OF REGISTRAR

R. E. F. F. F.

25C. FUNERAL DIRECTOR

R. E. F. F. F.

ADDRESS

2431 E. Oliver St.

VALLEY CO. CO.

U.S.A.

Original Contract

Medical

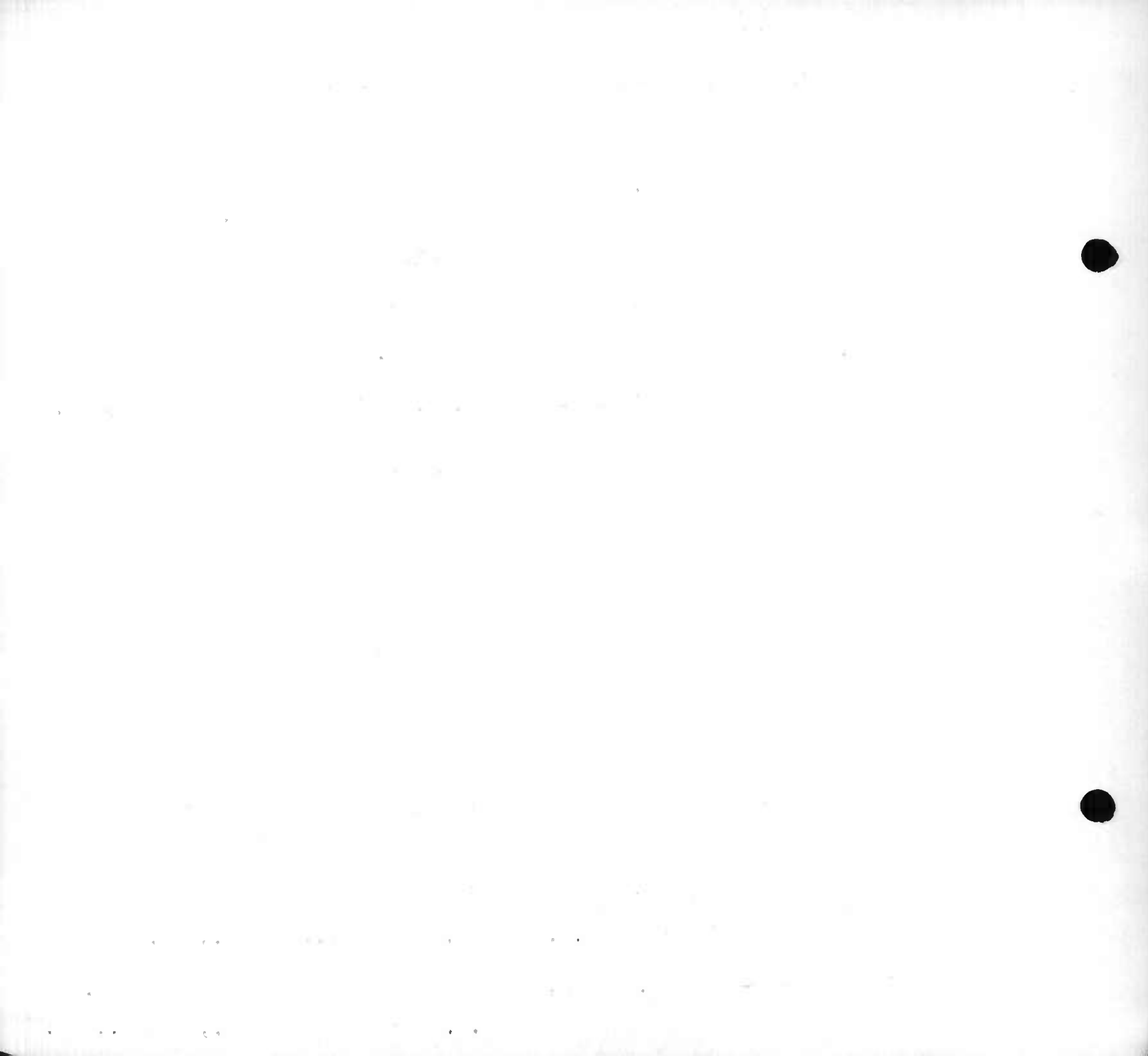
Bill for to American General, Baltimore, Md.  
Payable to the order of



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">70 00514</span>
BIRTH NO. <span style="float: right;">M-230 70 00514</span>				
1. NAME OF DECEASED (Type or Print) <b>Julia Helen McCann</b>		2. DATE AND HOUR OF DEATH <b>1-14-70</b> <span style="float: right;">11 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 322 Woodbourne Ave.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2712</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>322 Woodbourne Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1880</b>	9. AGE (In years last birthday) <b>89</b> 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Storage</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>James J. McCann</b>		14. MOTHER'S MAIDEN NAME <b>Julia E. Cassidy</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-22-9584</b>		17. INFORMANT <b>P. D. Williams</b> ADDRESS <b>Takoma Park, Md.</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>M.I.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ASHD</b> (B) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March</b> 19 <b>65</b> to <b>present</b> 19 <b>69</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 7</b> 19 <b>69</b> and that (in my) ( <del>four</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>Philip J. Wagley M.D.</b>		23B. DATE SIGNED <b>1-15-1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>Philip Wagley M.D.</b>		23D. ADDRESS <b>9 E. Chase St., Balto., Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-16-70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Marys, Govans</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

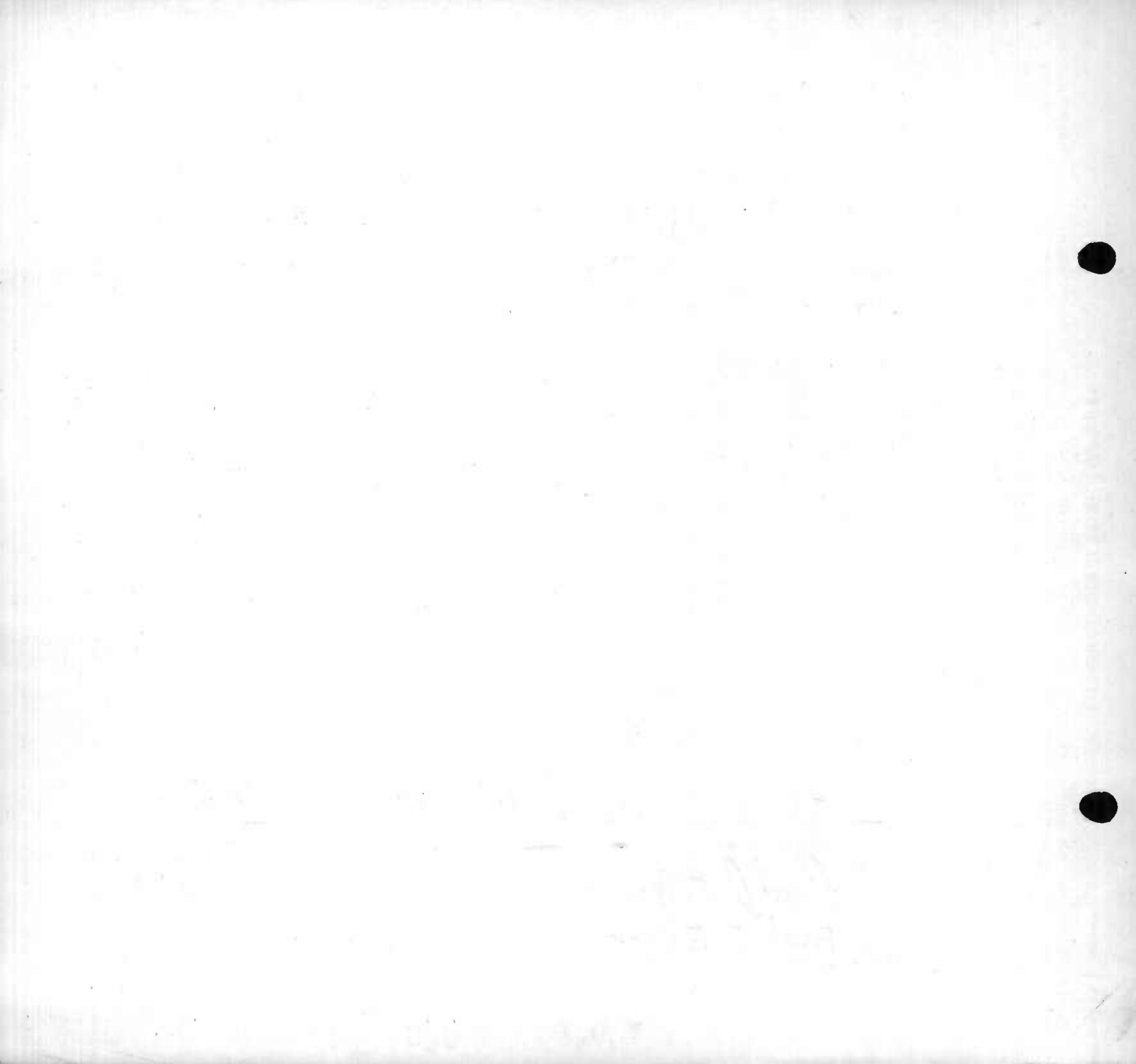
C-552 70 00515		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00515	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>CUNNINGHAM, ARMANTHA</b>			
2. DATE AND HOUR OF DEATH <b>1/15/70 8:30A M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b> <b>Broadway &amp; Fayette St.</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>F</b>				6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		8. DATE OF BIRTH <b>5-10-86</b>	
13. FATHER'S NAME <b>JOHN HADDOX</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Bates</b>		9. AGE (in years last birthday) <b>83</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harmer P. H. Shenniston, Jr.</b>	
18. <b>284X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute renal failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bone marrow depression (Pancytopenia)</b> <b>Chlor. unk.?</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute renal failure</b> (B) <b>Bone marrow depression (Pancytopenia)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chlor. unk.?</b> (C) <b>Pancytopenia, chlor. unk.?</b> <b>Asclvd, Acute MI &amp; CHF</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Asclvd, Acute MI &amp; CHF</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12</b> 19 <b>69</b> to <b>Jan. 15</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Jan. 15</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>C. Vergara M.D.</b> 23B. DATE SIGNED <b>1-15-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORAZON Z. VERGARA M.D.</b>		23D. ADDRESS <b>Church Home &amp; Hospital 100 N. Broadway Baltimore Md. 70</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>1-18-1970</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Sardis Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Harrison County, W. Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4906 York Road Balto., Md. 21212</b>		25D. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25E. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>	



# FUNERAL DIRECTOR: IMPORTANT

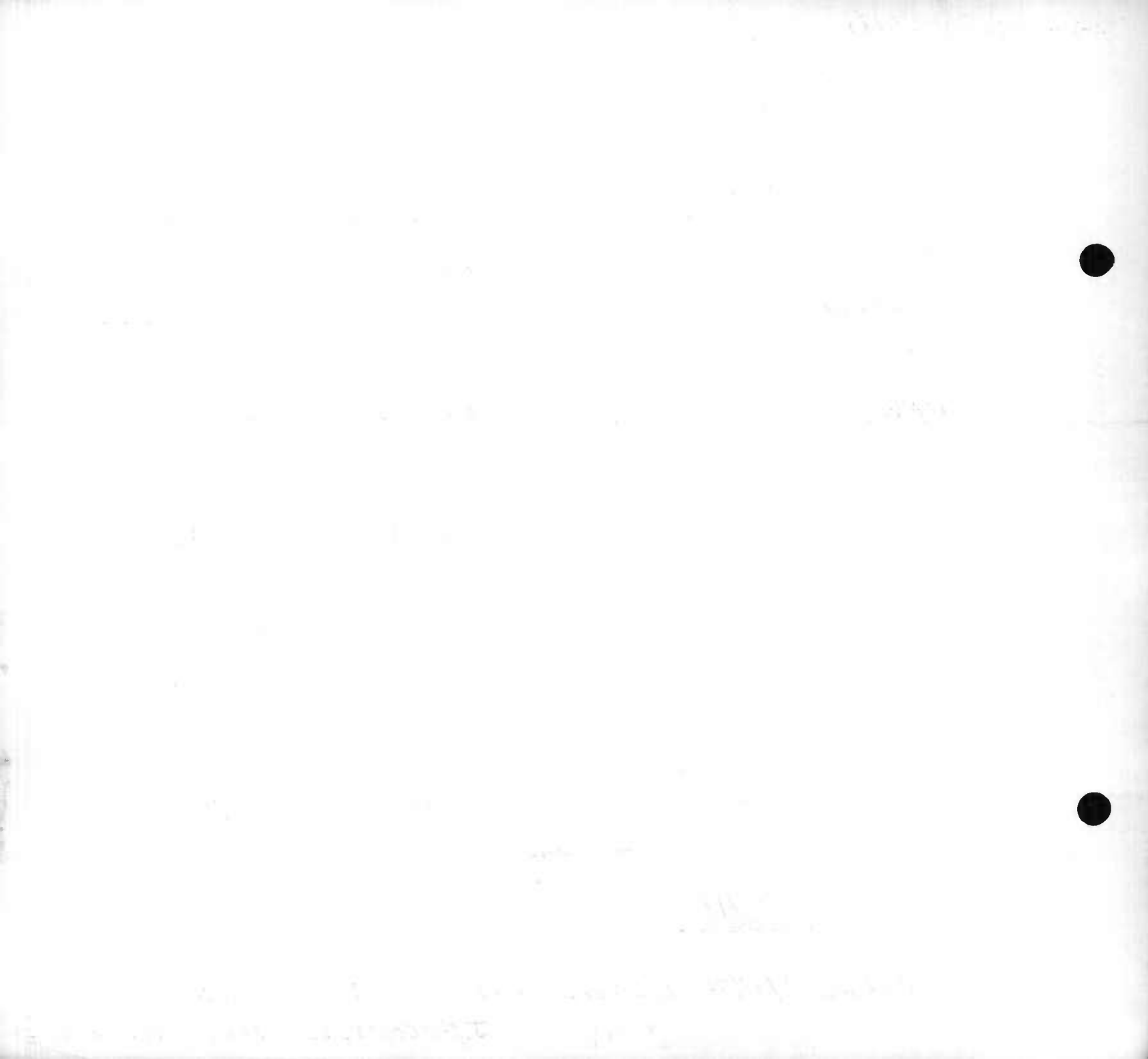
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00516</u>
BIRTH NO. <u>R-534</u>		70 00516		
1. NAME OF DECEASED (Type or Print) <u>RICHARD H. RANDALL</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 14, 1970</u> <u>7:50</u> <u>PM</u> <u>M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>GOOD SAMARITAN HOSPITAL</u> ADDRESS OR LOCATION <u>5601 LOCH RAVEN BLVD 21212</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3906 CLOVER HILL ROAD 21212</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-96</u>	9. AGE (In years lost birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. President</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Maron's Candy Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Danial R. Randall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Harding</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>316078925</u>		17. INFORMANT <u>Richard H. Randall, Jr.</u>
		ADDRESS <u>Same</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>x YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>11/19/69</u> 19 to <u>1/14/70</u> 19, that (I) <del>was</del> last saw the deceased alive on <u>1/14/70</u> 19 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>Paul J Edgar</u>		23B. DATE SIGNED <u>1/14/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Paul J Edgar</u>		23D. ADDRESS <u>Good Samaritan Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-19-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>
		ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>B-260</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 00517</b>	
1. NAME OF DECEASED (Type or Print) <b>Mary Baker</b>			2. DATE AND HOUR OF DEATH <b>1/14/70 5:32 M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS</b>			A. STATE <b>Maryland</b>		
4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1130 W. Hamburg Street 21230</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-7-25</b>	9. AGE (in years last birthday) <b>44</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Wayne Hunt</b>			14. MOTHER'S MAIDEN NAME <b>Martha Triplett</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>	
18. <b>427.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiogenic Shock 8 hrs.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>-</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Renal Failure</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1/2/70</b> to <b>1/14/70</b> and that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/14/70</b> and that (in my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Jack D. Mc Cue M.D.</b>			23B. DATE SIGNED <b>1/14/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Jack D. Mc Cue M.D.</b>			23D. ADDRESS <b>Baltimore City Hospitals 21224</b> <b>4940 Eastern Avenue Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/17/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J. G. CONNELLY SONS 300 MACE</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660 GIRTH NO.		70 00518		BALTIMORE CITY HEALTH DEPARTMENT		X		Registered No. 70 00518	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MINNIE GREER</b>				2. DATE AND HOUR OF DEATH <b>1-13-70 5:45 AM</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MD Genl Hosp Balt.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>5300</b>					
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>				8. DATE OF BIRTH <b>28 Nov 1876</b>		9. AGE (In years last birthday) <b>93</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Caldwell County N.C.</b>	
13. FATHER'S NAME <b>Milton GREER</b>				14. MOTHER'S MAIDEN NAME <b>ELIZIE Elizabeth Greer</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>				16. SOCIAL SECURITY NO. <b>2-23-01-3072</b>		17. INFORMANT <b>EVA Sullivan 606 Hyde Park Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>41242 E887X</b>				CAUSE OF DEATH <b>Wound infection, rt hip.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO <b>Fractured rt hip and infection of Austin Moore</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO <b>Fracture, @ hip; Wound infection</b>					
19A. DATE OF OPERATION <b>11-20-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>fractured rt hip</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HORTON BOARDING HOME</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) <b>11-18-69</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from <b>11-18 1969</b> to <b>1-13 1970</b> , that (X) (we) last saw the deceased alive on <b>1-13 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Michael P. Buchness</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/13/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL P. BUCHNESS</b>				23D. ADDRESS <b>827 LINDEN BALTO</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/13/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>GRANDON Baptist Church</b>		24D. LOCATION (City, town, or county) (State) <b>Caldwell County N.C.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jarboe, Jr.</b>		25C. FUNERAL DIRECTOR <b>Consolidated Funeral Home</b>		ADDRESS <b>300</b>			

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		70 00519	
M-600 70 00519				CERTIFICATE OF DEATH					
BIRTH NO.				2. DATE AND HOUR OF DEATH		11/13/70		11 45 P.M.	
1. NAME OF DECEASED (Type or Print) MOHR, FRED				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Maryland		B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER		430 Delaware Avenue		21221	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224									
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-1899		9. AGE (in years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY CITY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB MOHR				14. MOTHER'S MAIDEN NAME MATILDA SPADE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO. 214-22-6221 A		17. INFORMANT		ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		17 DAYS	
I				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct					
II				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 11/13/70 to 1/13/70 and that (I) (we) last saw the deceased alive on 1/13/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Lee J. Cordova MD				23B. DATE SIGNED 1/13/70					
23C. PHYSICIAN'S NAME (Type) Lee J. Cordova				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/17/70		24C. NAME of CEMETERY or CREMATORY ZION LUTHERAN		24D. LOCATION (City, town, or county) BALTO. MD.		(State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR Robert E. Sabers MD		25C. FUNERAL DIRECTOR J. J. CONNELLY		ADDRESS 300 MACE			

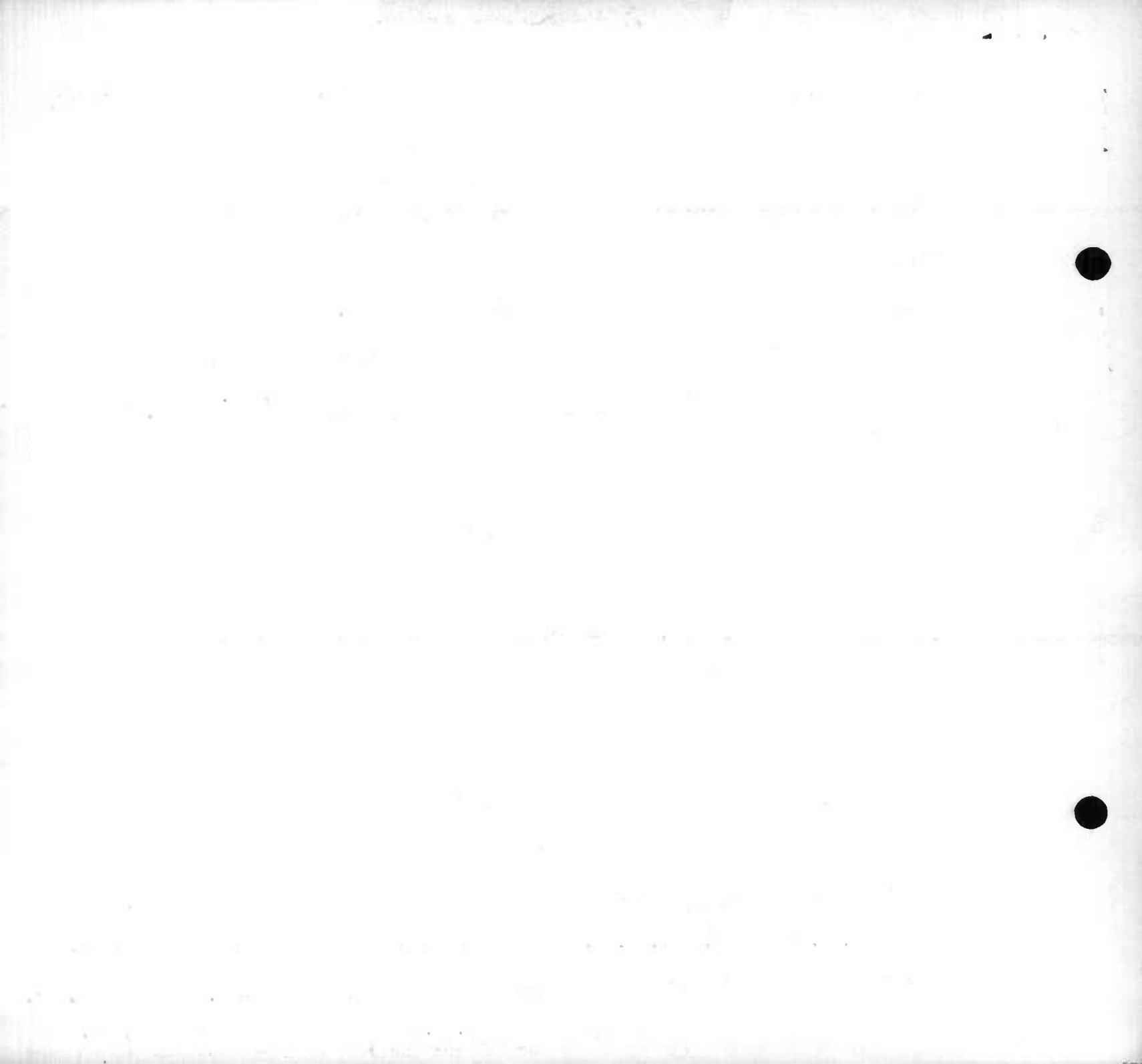
1/1/10

Mr. J. G. Jones

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

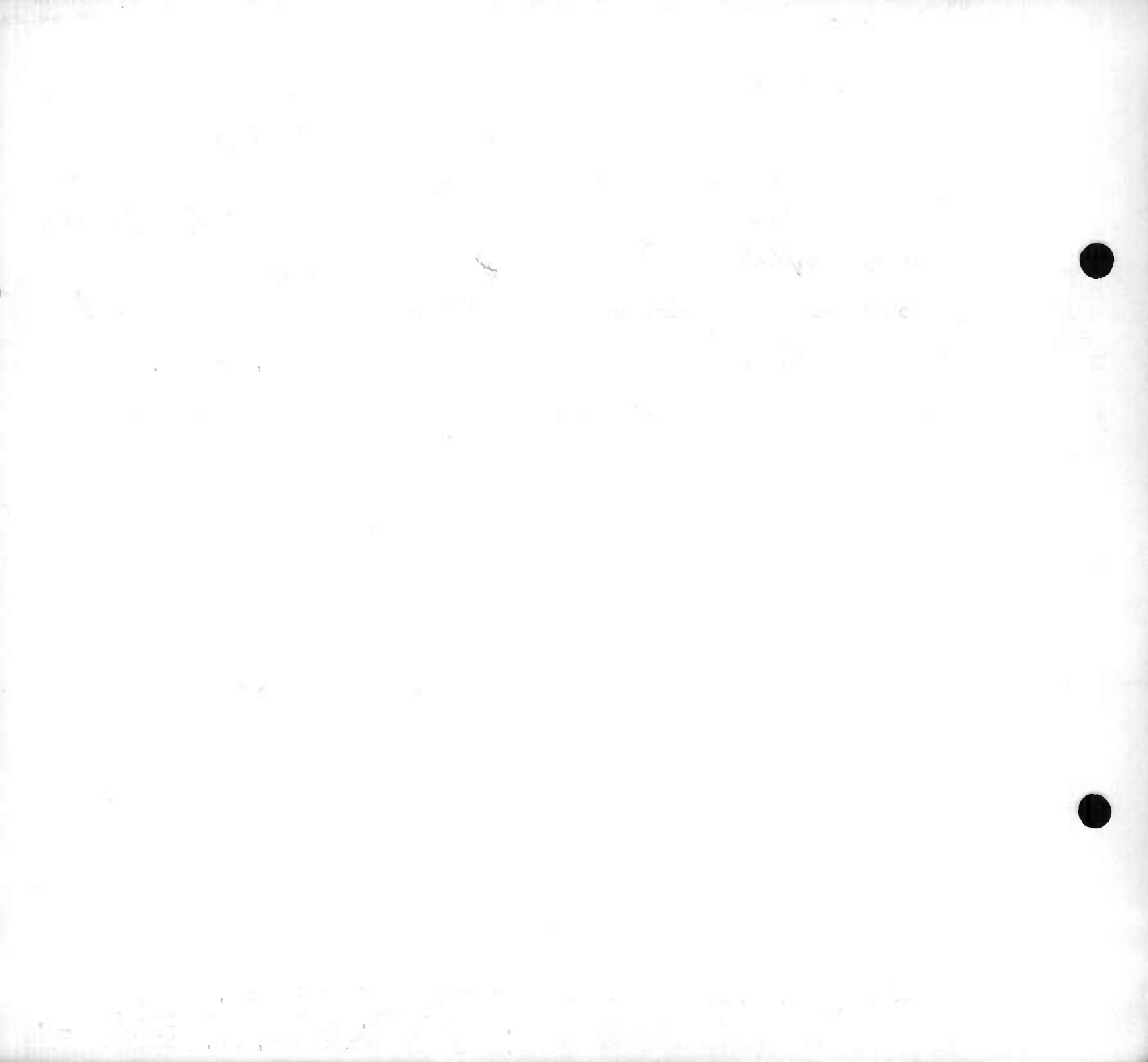
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00520	
BIRTH NO.		70 00520		70 00520	
1. NAME OF DECEASED (Type or Print)		Ward, Mary		2. DATE AND HOUR OF DEATH Jan 14, 1970 3:00 am	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Pennsylvania Franklin		5. SEX Female	
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN Chambersburg		6. RACE White	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/8/92		9. AGE (in years last birthday) 77		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA		10B. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME Michael Gilbert		14. MOTHER'S MAIDEN NAME Virginia Allemann		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 207-44-5326		17. INFORMANT Thomas N. Ward--Chambersburg Pa.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic Cardiovascular Disease CERIFICATION APPROVED BY [Signature] EXAMINER IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DIGITALIS INTOXICATION ? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Crania Cerebral Injuries Multiple syncopal episodes and falls APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 330 4th St, Chambersburg Pa.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-27-69 Evening		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down stairs during Syncope	
22. I certify that (1) (this hospital) attended the deceased from Jan 13 1970 to Jan 14 1970 that (1) last saw the deceased alive on Jan 14 1970 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (1) (did) view the body after death.					
23A. SIGNATURE N. F. Adkinson, Jr., M.D.				23B. DATE SIGNED Jan 14, 1970	
23C. PHYSICIAN'S NAME (Type) N. F. Adkinson, Jr., M.D.				23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/1970		24C. NAME OF CEMETERY or CREMATORY Lincoln Cemetery	
24D. LOCATION Chambersburg-Pa.-Franklin Co. Pa.		25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR J. F. Eline & Sons Reisterstown, Md.	
25C. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.		25D. ADDRESS For Sellers Funeral Home-Chambersburg Pa.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				X REG. NO. 70 00521
C-200 70 00521				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CZAKO, Catherine</i>		
2. DATE AND HOUR OF DEATH <i>1-10-70 11:20 A.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secour</i>		A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN <i>Piera Beach</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>237 Kenwood Rd 2122</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-28-23</i>	9. AGE (in years last birthday) <i>46</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Finance</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Wm. J. McGhee</i>		14. MOTHER'S MAIDEN NAME <i>Heiderman, Anna C.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216 14 7685</i>		17. INFORMANT <i>Pt Chark (Hospital)</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastatic Carcinoma.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CA. Breast.</i>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) I APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>12-21-69</i> to <i>1-10-70</i> that (I) (we) last saw the deceased alive on <i>1-10-70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Varah Vorasubin</i>		23B. DATE SIGNED <i>1-10-1970</i>		
23C. PHYSICIAN'S NAME (Type) <i>VARAH VORASUBIN, M.D.</i>		23D. ADDRESS <i>Bon Secours Hosp. Balto, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1/14/70</i>	24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 16 1970</i>	25B. NAME OF REGISTRAR <i>George J. Gonce</i>	25C. FUNERAL DIRECTOR <i>George J. Gonce</i>	ADDRESS <i>4001 Ritchie H.y. Baltimore, Md. 21225</i>	

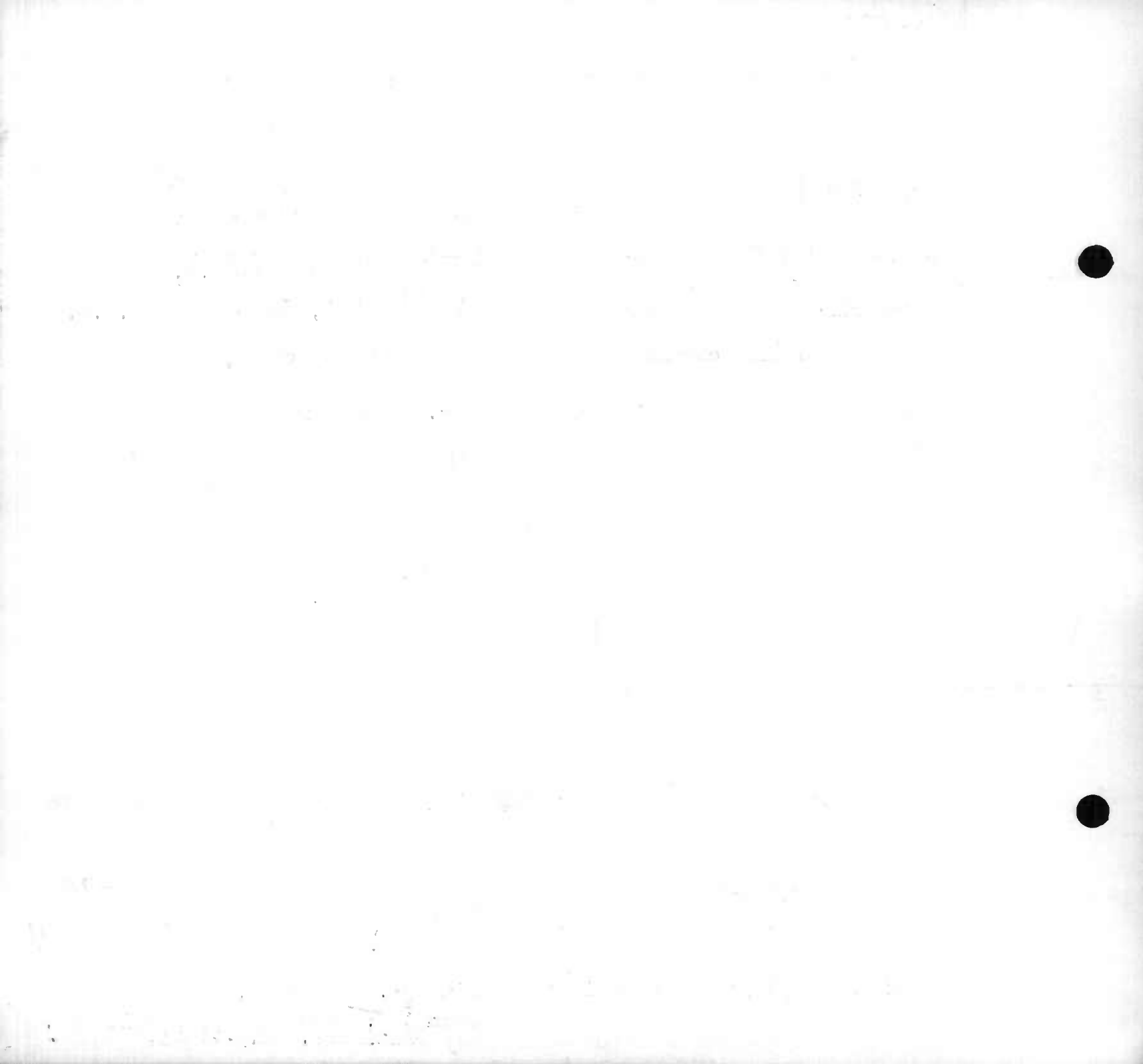




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 00522	
BIRTH NO. <u>S-556</u>		70 00522			
1. NAME OF DECEASED (Type or Print) <u>HELEN B. SIMONAIRE</u>			2. DATE AND HOUR OF DEATH <u>JAN 12 1970 12:05P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Balt Genl Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>AA Co</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>430 5th Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-90</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Leopold Schuarz</u>			14. MOTHER'S MAIDEN NAME <u>Carrie ? Schuman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 07 7578</u>	17. INFORMANT ADDRESS <u>Mrs. Helen Gorman Same</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>2 to Acute Psych</u> <u>? Obstruction.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Possible Cause of lung</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <u>12-9-69</u> to <u>12-03-12-1-1970</u> that (if we) last saw the deceased alive on <u>12-05-12-1-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry Chen M.D.</u>			23B. DATE SIGNED <u>12-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>HENRY CHEN M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/15/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Pk.</u>
24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1970</u>		
25B. NAME OF REGISTRAR <u>George J. Gonce</u>			25C. FUNERAL DIRECTOR ADDRESS <u>4001 Ritchie Hgy. Baltimore, Md. 21225</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00523</u>
BIRTH NO. <u>C-400</u>		70 00523		70 00523
1. NAME OF DECEASED (Type or Print) <u>COLE ADELE W.</u>		2. DATE AND HOUR OF DEATH <u>1-14-1970 1:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>420 NORTHWAY</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1900</u>	9. AGE (In years last birthday) <u>69</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James E. Waugh</u>		
14. MOTHER'S MAIDEN NAME <u>Laura McLaughlin</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>214-18-9415</u>		17. INFORMANT ADDRESS <u>Thomas W. Cole 6309 Bellona Ave. Balto. Md</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ACUTE MYOCARDIAL INFARCTION</u> <u>ACUTE PULMONARY EDEMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>HISTORY OF MYOCARD. INFARCTION</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>12-5-1969</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1-14-1970</u> to <u>1-14-1970</u> and that (I) (we) last saw the deceased alive on <u>1-14-1970</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. Paul Mikus M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>J. PAUL MIKUS</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>1/17/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld</u>		
25D. ADDRESS <u>Home 6500 York Rd. Balto.</u>				

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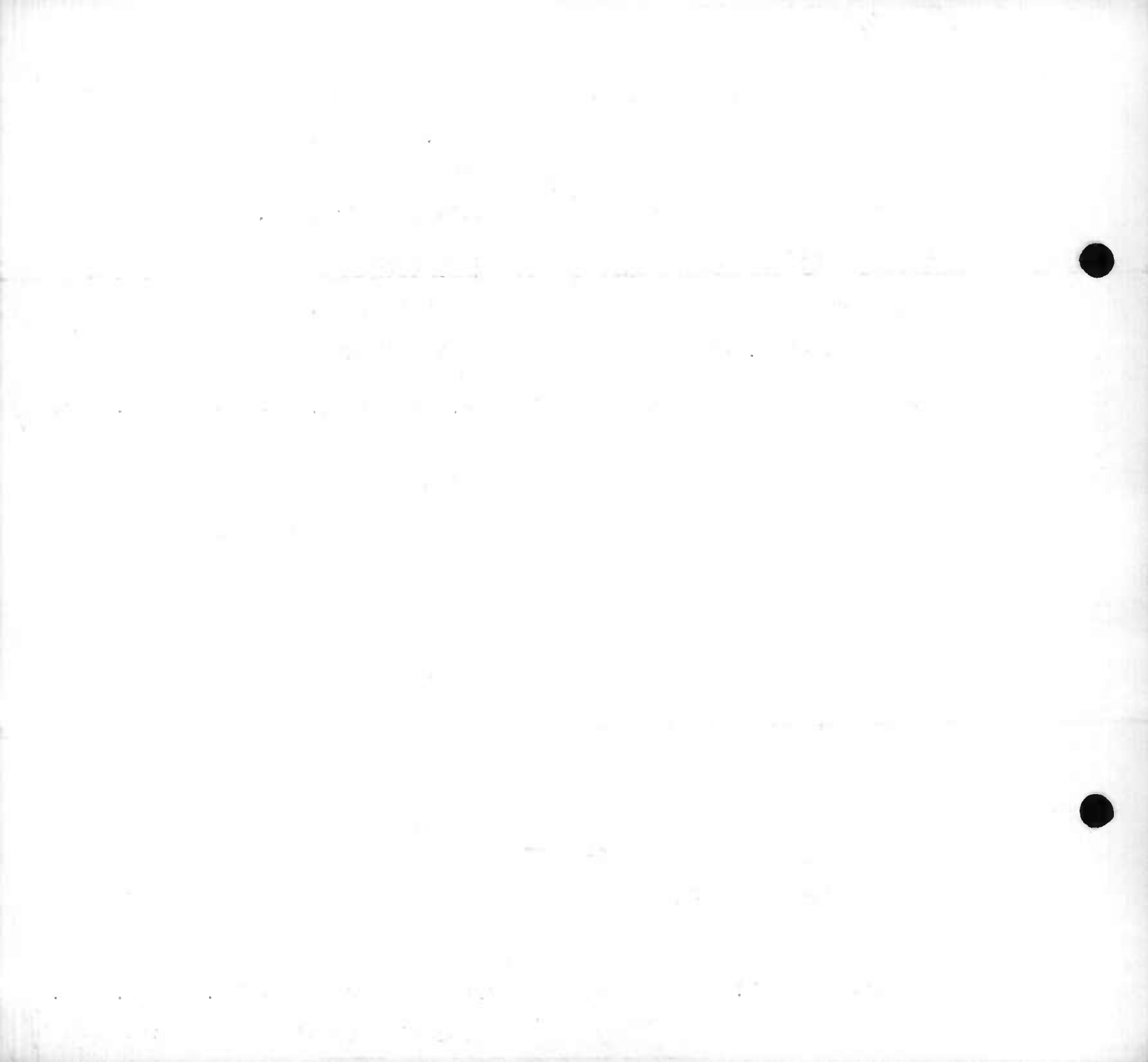
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4-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-545 70 00524		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 00524	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>ELEANOR B Conlon</b>			2. DATE AND HOUR OF DEATH <b>1-10-70 4:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY Hospital</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>Towson</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>10 24 1888</b> 9. AGE (in years last birthday) <b>81</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank J. Flannery</b>	
14. MOTHER'S MAIDEN NAME <b>Ella Brannon</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-44-1580</b>	
17. INFORMANT <b>Mr. Charles C. Conlon</b>		ADDRESS <b>115 St. Dunstan</b>		18. <b>41241</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PULMONARY EMBOLISM</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CONGESTIVE HEART FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		<b>1 YR</b>	
(C) <b>ASCVD</b>				<b>30 YR</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month   Day   Year   Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 9</b> 19 <b>70</b> to <b>JAN 10</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>JAN 10</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>did</b> view the body after death.					
23A. SIGNATURE <b>Robert J. Rosenstock M.D.</b>		23B. DATE SIGNED <b>1/10/70</b>		23C. PHYSICIAN'S NAME (Type) <b>MERCY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Cathedral Cemetery</b>	
24D. LOCATION <b>Frederick Rd. Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 16 1970</b>		25B. NAME OF REGISTRAR <b>Michelle Wiedefeld</b>	
25C. FUNERAL DIRECTOR <b>Michelle Wiedefeld</b>		ADDRESS <b>Hme 6500 York Rd</b>			



C-623

70 00525

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00525

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) RUTH H. CHRISTOPHER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 222 St. Paul Street, Apt. 2204		3. DATE PRONOUNCED DEAD Month Day Year Hour January 10, 1970 10:05 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/13/1910		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 39		E. STREET AND NUMBER 222 St. Paul Street, Apt. 2204	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carroll B. Hoffman		14. MOTHER'S MAIDEN NAME Grace I. Bowersock	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		16. KIND OF BUSINESS OR INDUSTRY Clothing	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO.		18. SOCIAL SECURITY NO. 217146904	
19. 571.81		20. INFORMANT ADDRESS Mrs. Robert Avery 129 Hopkins Rd.	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 11, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/13/70	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.		ADDRESS	

Letter from M.E.'s office

3-11-70

M.H.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

Called Harbor View Nursing Home. address of deceased.  
is 279 Oakley Village.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00527	
C-240 70 00527				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Benjamin M. Chesley		2. DATE AND HOUR OF DEATH 1/15/70 1:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2710		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore Inc. 42			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 802 E. Goldspring Lane #12		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1900	9. AGE (In years last birthday) 69	If Under 1 Tr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Ernest Chesley son ADDRESS same Carlos R. Perel Md. Sinai Hospital
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE G.I. Bleeding DUE TO, OR AS A CONSEQUENCE OF: (B) Necrotizing Periarthritis DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive Heart Failure Nephritis Syndrome		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years 2 years.		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 12 1970 to January 15 1970 that (I) (we) last saw the deceased alive on January 14 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Perel				23B. DATE SIGNED 1/15/70	
23C. PHYSICIAN'S NAME (Type) Carlos R. Perel				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970			
25B. NAME OF REGISTRAR Kelson F.H.		25C. FUNERAL DIRECTOR V.R. BAILEY 1348 C. Lhoun Street			



1  
C-500 70 00528 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 00528

1. NAME OF DECEASED (Type or Print) JOHN CONWAY		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 531 Gold Street		3. DATE PRONOUNCED DEAD January 13, 1970		Month	Day	Year	Hour 4:40 P.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 2-8-88		10. AGE (In years lost birthday) 8		11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-10-8050		18. INFORMANT John Conway - Rt. 1 Box 268, Marion St. Md.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 16 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR U. BAILEY		ADDRESS 1348 Calhoun St.	

WCA/REK/ (E) (M)

THE CONTENT

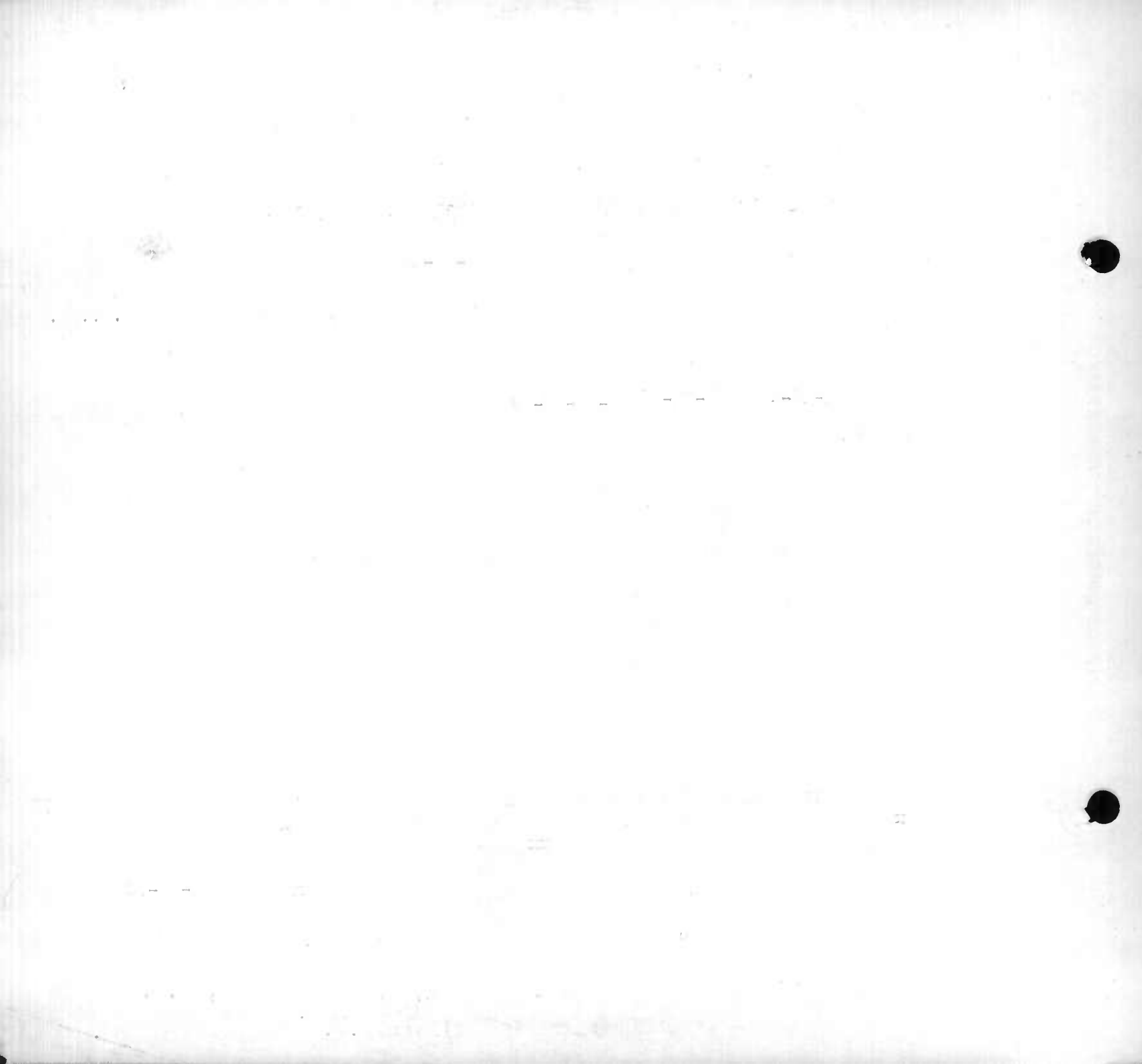
VALLEY PROPERTY

U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00529
CERTIFICATE OF DEATH				
BIRTH NO. <b>P-630</b>		70 00529		
1. NAME OF DECEASED (Type or Print) <b>PURDIE, Eddie Lee</b>		2. DATE AND HOUR OF DEATH <b>14 JANUARY 1970 11:25 A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3231 PRESSMAN STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-09</b>	9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ELIZABETHTOWN, NORTH CAROLINA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>APRIL PURDIE</b>		
14. MOTHER'S MAIDEN NAME <b>COSTILA MELVIN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 11-17-43 TO 6-21-45</b>		
16. SOCIAL SECURITY NO. <b>243-18-05-80</b>		17. INFORMANT <b>VA HOSPITAL RECORDS</b> ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>		
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>14 DECEMBER 19 69</b> to <b>14 JANUARY 19 70</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>14 JANUARY 19 70</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>SAMI A BRAHIM, MD</b>		23B. DATE SIGNED <b>1-15-70</b>		23C. PHYSICIAN'S NAME (Type) <b>SAMI A BRAHIM, MD</b>
23D. ADDRESS <b>3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1-18-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Church Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hope Mill, N.C.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1970</b>		25B. NAME OF REGISTRAR <b>Nelson F. H.</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>1348 C. Choun St.</b>

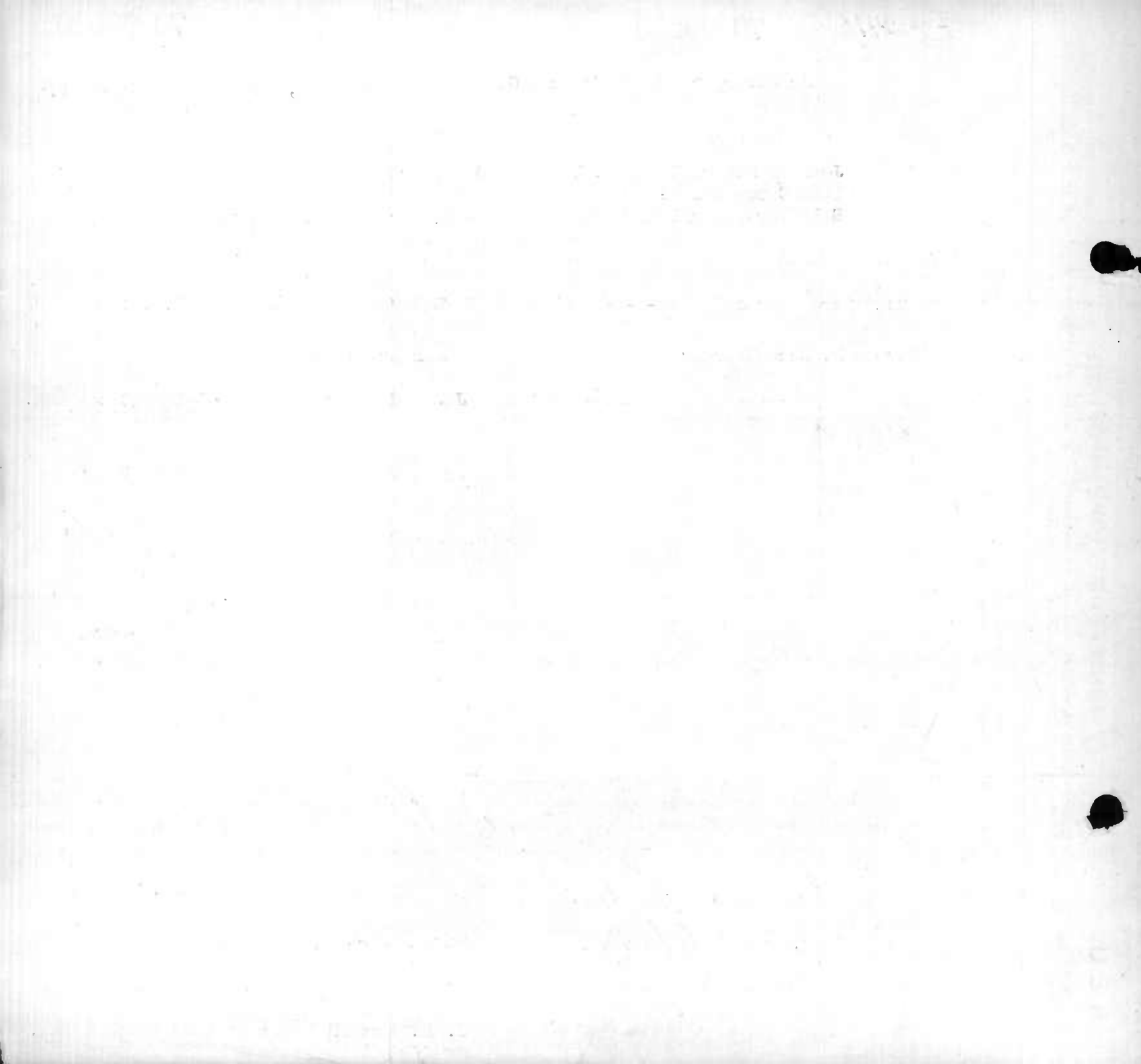




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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00530</u>
<b>E-241</b> <b>70 00530</b> <b>CERTIFICATE OF DEATH</b>		<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Eichelberger Miss Francis G.</u>		
<b>2. DATE AND HOUR OF DEATH</b> <u>January 9, 1970</u> <u>9:25 P/</u> M.		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Jenkins Memorial Hospital</u> <u>1000 Caton Avenue</u> <u>Baltimore, Maryland 21229</u>		
<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2716</u>		<b>5. SEX</b> <u>Female</u> <b>6. RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		
<b>8. DATE OF BIRTH</b> <u>Nov. 101878</u> <b>9. AGE</b> (In years lost birthday) <u>91</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		<b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4613 Park Heights Avenue</u>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Registered nurse</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> - - - -		
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Libertytown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Herman H. Eichelberger</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Britcher</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-54-3381</u>		<b>17. INFORMANT</b> <u>Jenkins Memorial Hospital</u> <u>Baltimore, Md.</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>599.01</u> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>G.U. infection</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>ASCVD</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>48 hrs</u> <u>3 days</u> <u>years</u>		
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/9 1962</u> <b>to</b> <u>1/7 1970</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/9 1970</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>J. Raymond Gladue</u> <b>23C. PHYSICIAN'S NAME</b> (Type) <u>J. Raymond Gladue</u>				<b>23B. DATE SIGNED</b> <u>1/10/70</u>
<b>23D. ADDRESS</b> <u>1000 Caton Ave.</u>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		
<b>24B. DATE</b> <u>13 JAN 70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Loudon Park Cemetery</u>		
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 16 1970</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Valerie E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>J. E. Lowell Lemmon</u>		
<b>25D. ADDRESS</b> <u>4611 Park Hghts.</u>				



# FUNERAL DIRECTOR: IMPORTANT

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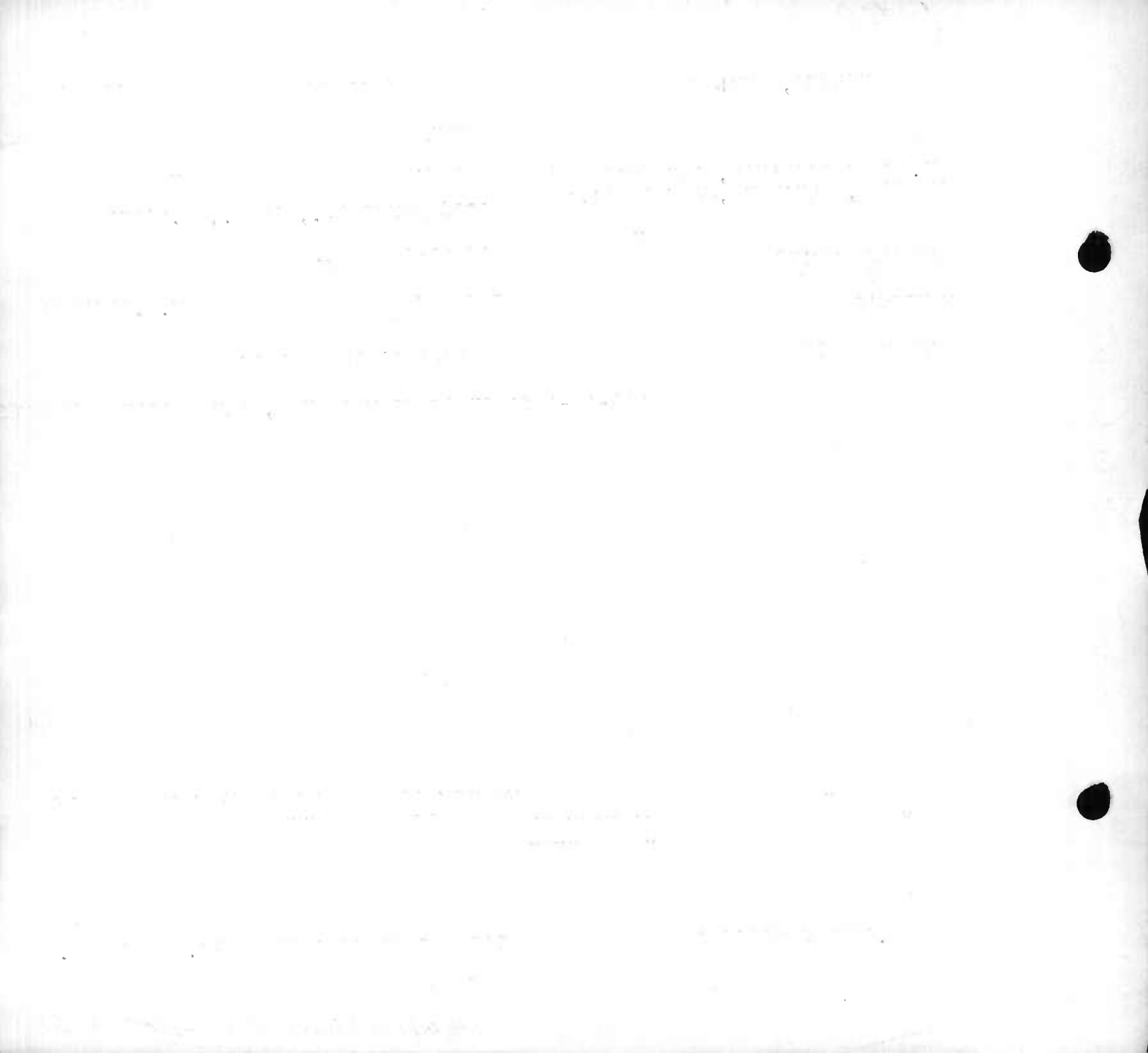
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">REG. NO. <span style="background-color: black; color: black;">70 00531</span></span>									
1. NAME OF DECEASED (Type or Print) <b>ALASKA STREET</b>					2. DATE AND HOUR OF DEATH <b>Jan 12, 1970 4:30p M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Edgewood Nursing Home 2712</b> B. COUNTY <b>Baltimore</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Edgewood Nursing Home 6000 Bellona Ave.</b>					C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <b>6000 Bellona Ave.</b>				
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-1-92</b>	9. AGE (In years lost birthday) <b>77</b>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Carter Street</b>					14. MOTHER'S MAIDEN NAME <b>Lydia Hughes</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-14-1843</b>		17. INFORMANT ADDRESS <b>Mrs. Roland Smith Rt. 1 Millers, Md.</b>				
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (1) (this hospital) attended the deceased from <b>June 19 69</b> to <b>January 12 19 70</b> , that (1) (we) last saw the deceased alive on <b>Jan 12 19 70</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>H. C. ALEVIZATOS, MD.</b> 23B. DATE SIGNED <b>Jan 13, 1970</b> 23C. PHYSICIAN'S NAME (Type) <b>H. C. ALEVIZATOS, MD.</b> 23D. ADDRESS <b>1209 St. Paul St. Balt. 21302</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>Jan. 15, 1970</b> 24C. NAME OF CEMETERY or CREMATORY <b>Immanuel Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Manchester Carroll Md.</b> 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR <b>1 9 7 0 0 0 0</b> 25C. FUNERAL DIRECTOR <b>Tinton - Elise Funeral Home</b> 25D. ADDRESS <b>Hampstead, Md.</b>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

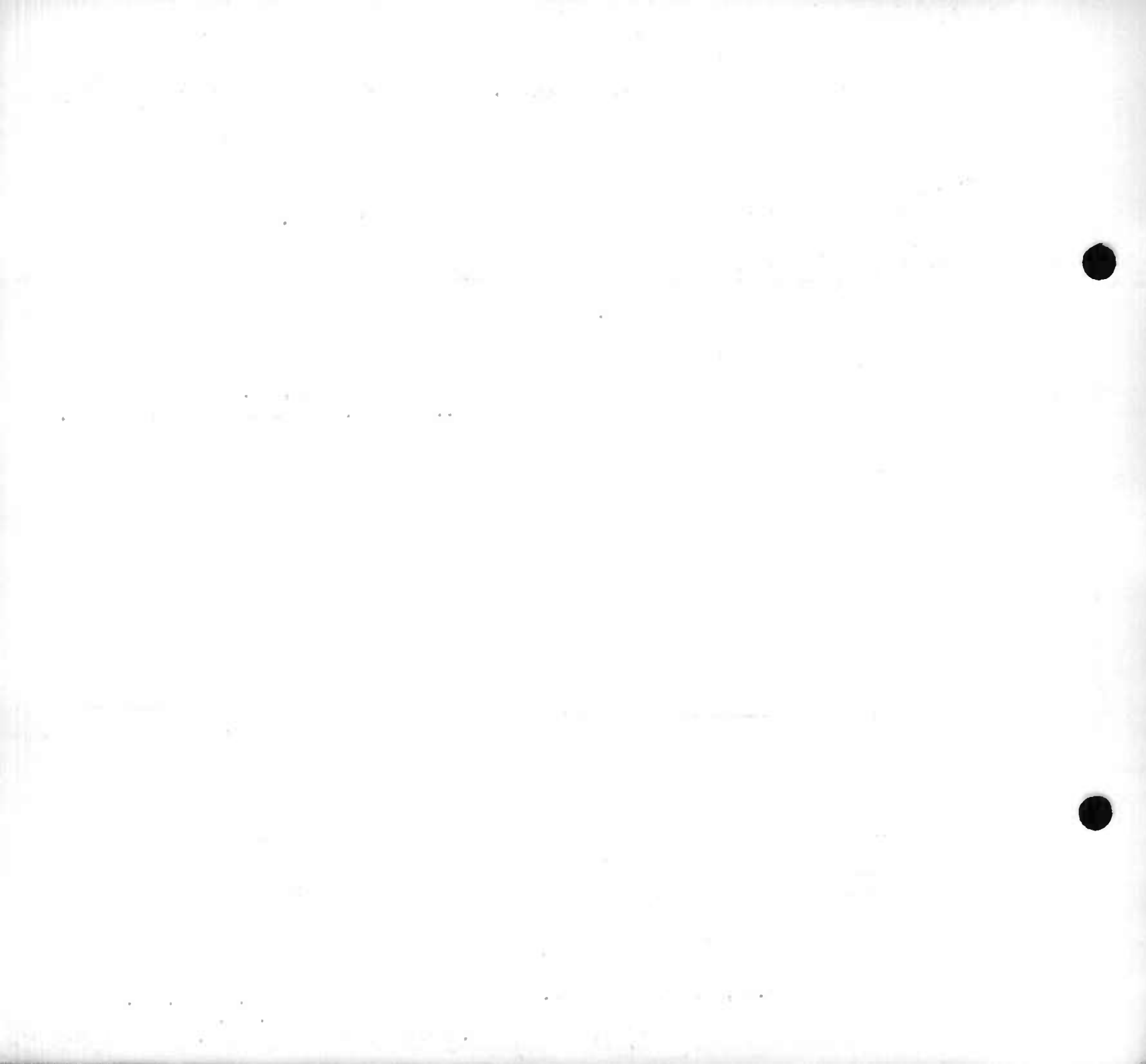
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00532	
BIRTH NO. 70 00532		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) VELJKO, EMMI			2. DATE AND HOUR OF DEATH 1/17/70 11 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL, WILKENS & CATON AVENUES, BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY 2102		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1316 JAMES ST., BALTO., MD. 21223		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/18	9. AGE (in years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S. CITIZEN		13. FATHER'S NAME GORN N PLOSS			
14. MOTHER'S MAIDEN NAME ANNA RALRLOD PLOSS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 214-38-4901		17. INFORMANT ADDRESS ST AGNES HOSPITAL, WILKENS & CATON AVENUES			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
(A) IMMEDIATE CAUSE Disseminated Carcinoma DUE TO, OR AS A CONSEQUENCE OF:					
(B) Rt Heart Carcinoma DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JANUARY 11 19 70 to JANUARY 17 19 70 that (X) (we) last saw the deceased alive on JANUARY 17 19 70 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Carlos M. Orbegoso			23B. DATE SIGNED 1-18-70		
23C. PHYSICIAN'S NAME (Type) DR. CARLOS ORBEGOSO			23D. ADDRESS CATON & WILKENS AVE AVE BALTO MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 21-70		24C. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEM.	
24D. LOCATION ELKRIDGE		24E. (City, town, or county) MD.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR THE DUBPEY BROS INC 1800 E LOMBARD ST	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00533</u>	
<div style="display: flex; justify-content: space-between;"> <span>M-324</span> <span>70 00533</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mitchell, Mr. William R.</u>		2. DATE AND HOUR OF DEATH <u>Jan. 13, 1970 7:45 P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <u>Baltimore, Md.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY <u>Harford</u>	
		C. CITY OR TOWN <u>Baltimore, Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>(927 Vanderwood Rd.)</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/05</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Laundry Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>William Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Addie George</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-6207</u>		17. INFORMANT <u>Catonsville, Md. 21228</u> <u>Mrs. Ethel L. Mitchell 927 Vanderwood Rd.</u>	
18. <u>412.31</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arterio-sclerotic heart disease - years</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-26-1969</u> to <u>1-13-1970</u> that (I) (we) last saw the deceased alive on <u>1-13-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Octavio A. Ruiz M.D.</u>		23B. DATE SIGNED <u>1/13/70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz M.D.</u>		23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 16, 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn Cem.</u>	
24D. LOCATION <u>Eastern Ave. Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Balto. Md. 21229</u> <u>G. Truman Schwab 5151 Balto. National Pike</u>			

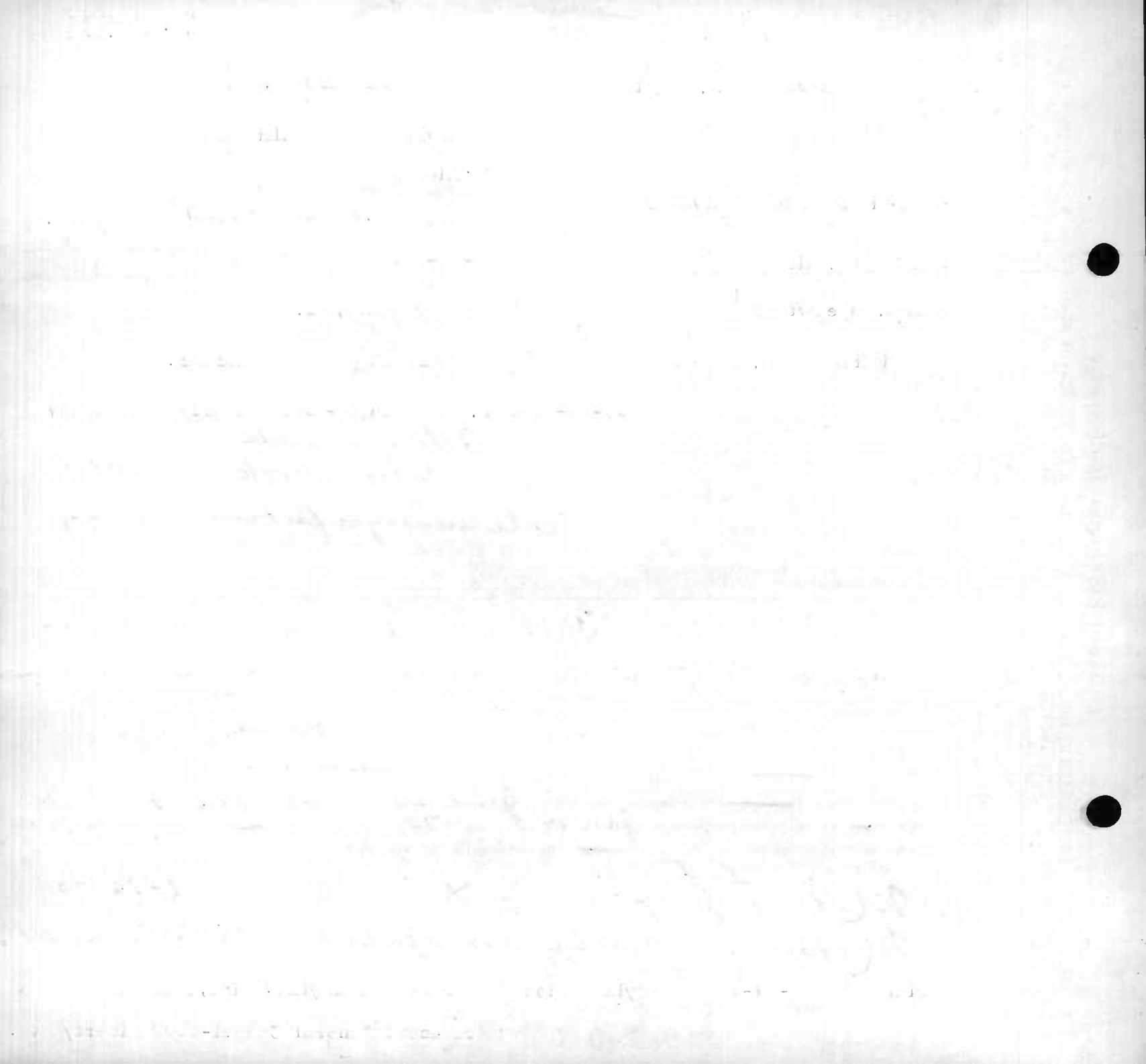




# FUNERAL DIRECTOR: IMPORTANT

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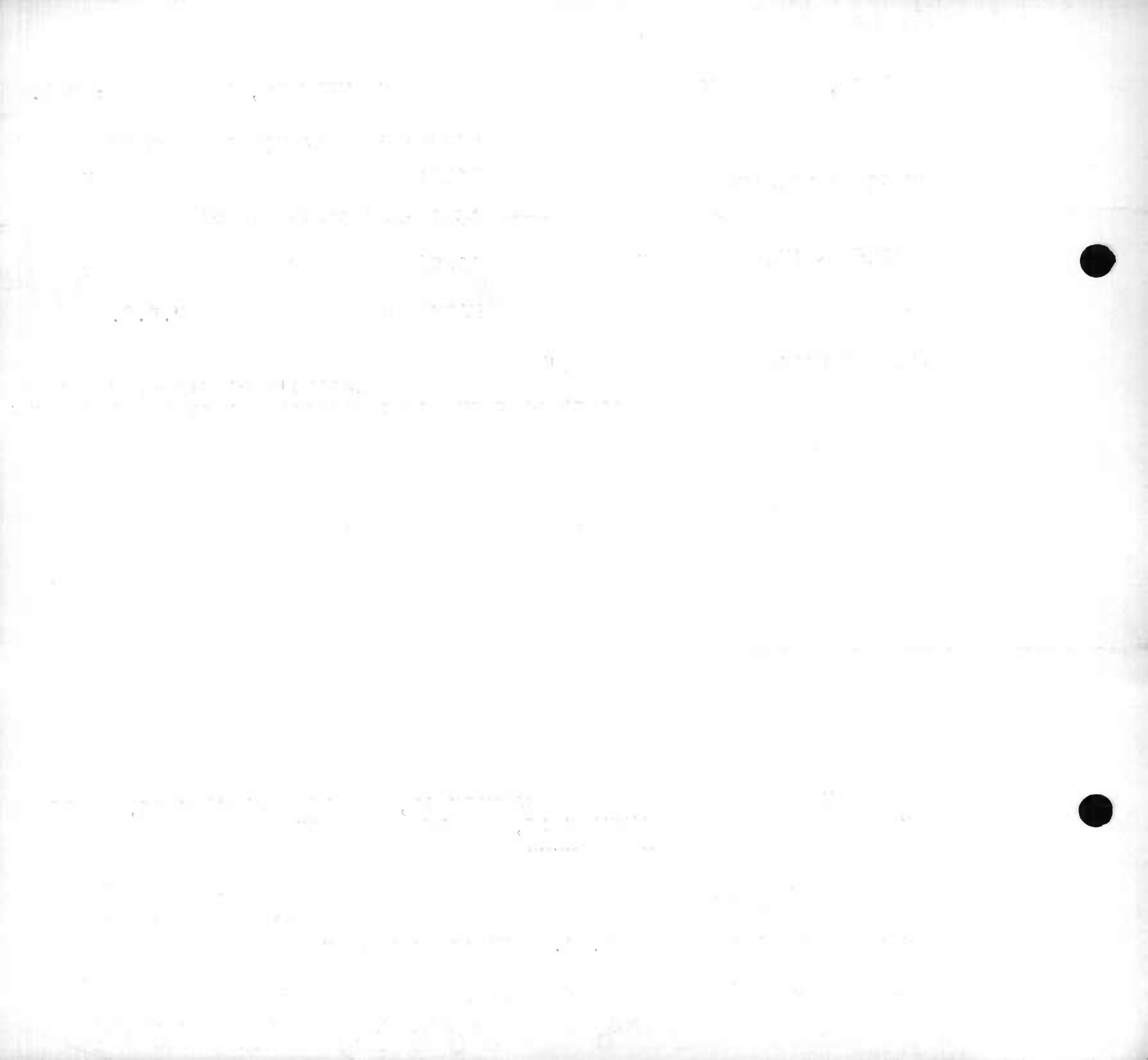
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00534</u>	
X-520 <b>70 00534</b>		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ruthven G. King		January 14, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>90</u> House in the Pines Belvedere		A. STATE		B. COUNTY	
		Maryland		Baltimore <u>C</u>	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		6404 Liberty Road 21207			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-11-1901	68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Maint. Supervisor				New Freedom, Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Winfield S. King		Hannah Hitchcock			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		139-10-9323		J. Hixenbaugh - 6404 Liberty Road 21207	
18. <u>599.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH <u>Splenic infarct with endotoxic shock</u>  <u>Acute urinary infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Parkinson's disease</u>		<u>5 yrs.</u>	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None	None	None	None		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
None	None	None			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>June 20</u> 19 <u>67</u> to <u>Jan 14</u> 19 <u>70</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Jan 14</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>William E. Lorman</u>				1-16-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>William E. Lorman</u>		<u>1401 Reservoir Lane Rd Belts 21008 Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	1-17-70	Maryland Line Cemetery		Maryland Line, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JAN 19 1970	<u>Robert E. Taylor</u>	Armstrong Funeral Chapel-4600 Liberty Hts.			



# FUNERAL DIRECTOR: IMPORTANT

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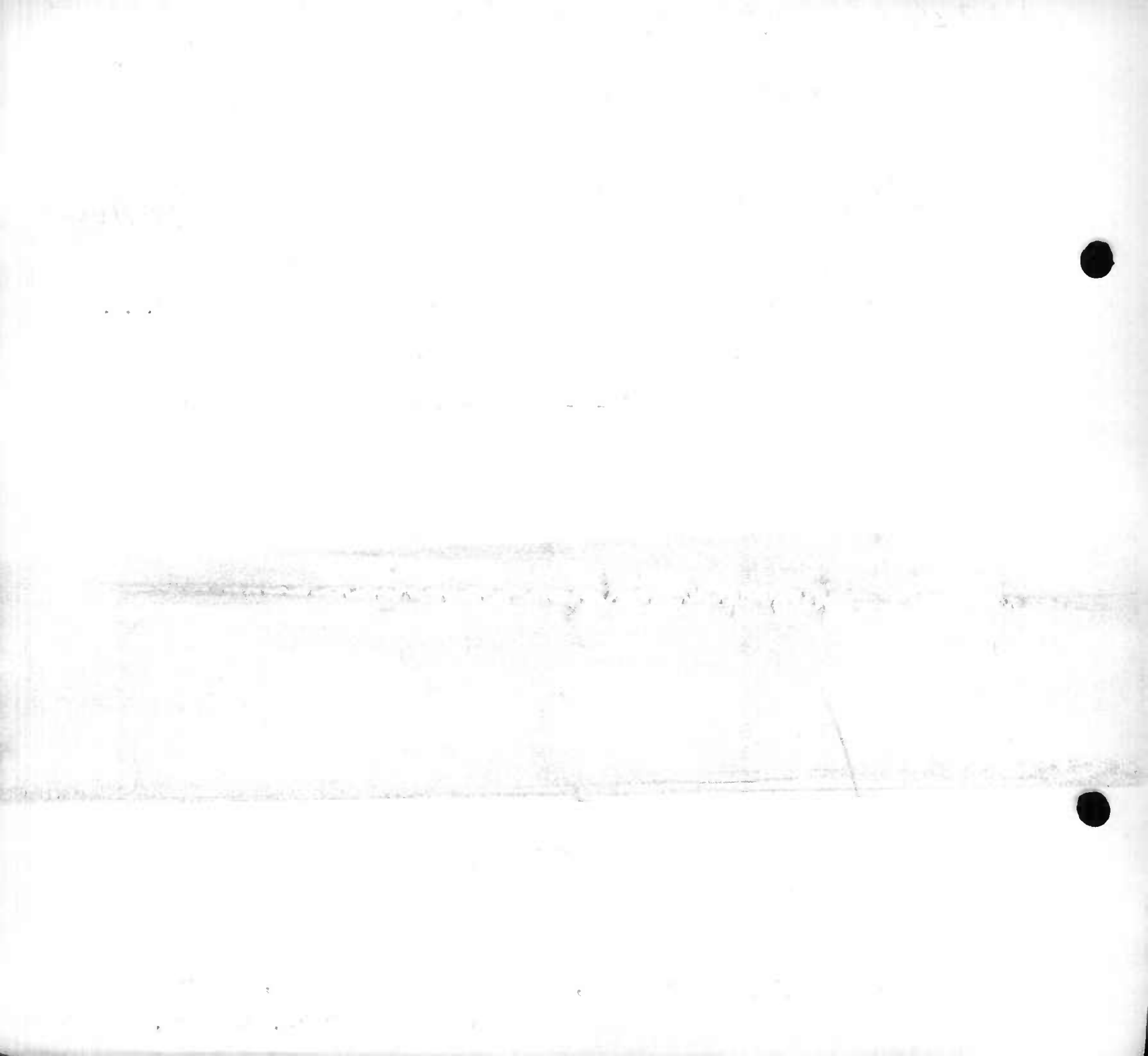
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 00535
F-623 70 00535				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FORREST, ANNA LAWSON</b>		
2. DATE AND HOUR OF DEATH <b>JANUARY 15, 1970 2:30 A.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>40</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER <b>1503 PARK GROVE AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/06/89</b>	9. AGE (in years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>WILLIAM PRICE</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213 54 0325</b>		
17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b>		ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. <b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE. <b>Pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Congested heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Atherosclerosis, generalized</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 12, 1970</b> to <b>JANUARY 15, 1970</b> that (X) (we) last saw the deceased alive on <b>JANUARY 15, 1970</b> and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE <b>Carlos M. Orbegoso</b>		23B. DATE SIGNED <b>1-15-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>CARLOS ORBEGOSO</b>		23D. ADDRESS <b>M. D. ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/17/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEM</b>	24D. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>	25C. FUNERAL DIRECTOR <b>E. &amp; MacKibbly</b>	ADDRESS <b>301 Frederick Rd. Baltimore MD 21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00536</u>	
4-632 70 00536		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Edwin W Hardesty</u>		2. DATE AND HOUR OF DEATH <u>1-14-70</u> <u>9:20 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u> B. COUNTY <u>841</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-93</u>		9. AGE (In years last birthday) <u>76.76</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Martha Chester</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-1449</u>		17. INFORMANT <u>Mrs Edna Hardesty</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE Myocardial Infarction complicated by myocardial rupture</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>1-14-70</u> to <u>1-14-70</u> that (I) (we) last saw the deceased alive on <u>1-14-70</u> and that (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leonard J. Ruck Inc.</u>		23B. DATE SIGNED <u>1-15-70</u>		23C. PHYSICIAN'S NAME (Type) <u>BAHANI L. MANALO, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore, Md</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		25D. ADDRESS <u>Baltimore, Maryland</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-452 70 00537</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>70 00537</b>	
M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Jacob E. Williams</b>		2. DATE AND HOUR OF DEATH <b>1/15/70 4:00 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital Baltimore, Maryland</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b>			
		D. STREET ADDRESS (If rural, give location) <b>2807 Ailsa Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/10/91</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor Clerical</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hugh F. Williams</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			
16. SOCIAL SECURITY NO. <b>217-16-5163</b>		17. INFORMANT <b>Mrs. Irene C. Williams</b>		ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO <b>Ventricular tachycardia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		(B) DUE TO <b>Septicemia</b>		<b>1 day</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Septicemia</b>				<b>1 day</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stuart V. Grandis</b> M.D.				23B. DATE SIGNED <b>1/15/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stuart V. Grandis</b> M.D.				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert F. [illegible]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>	

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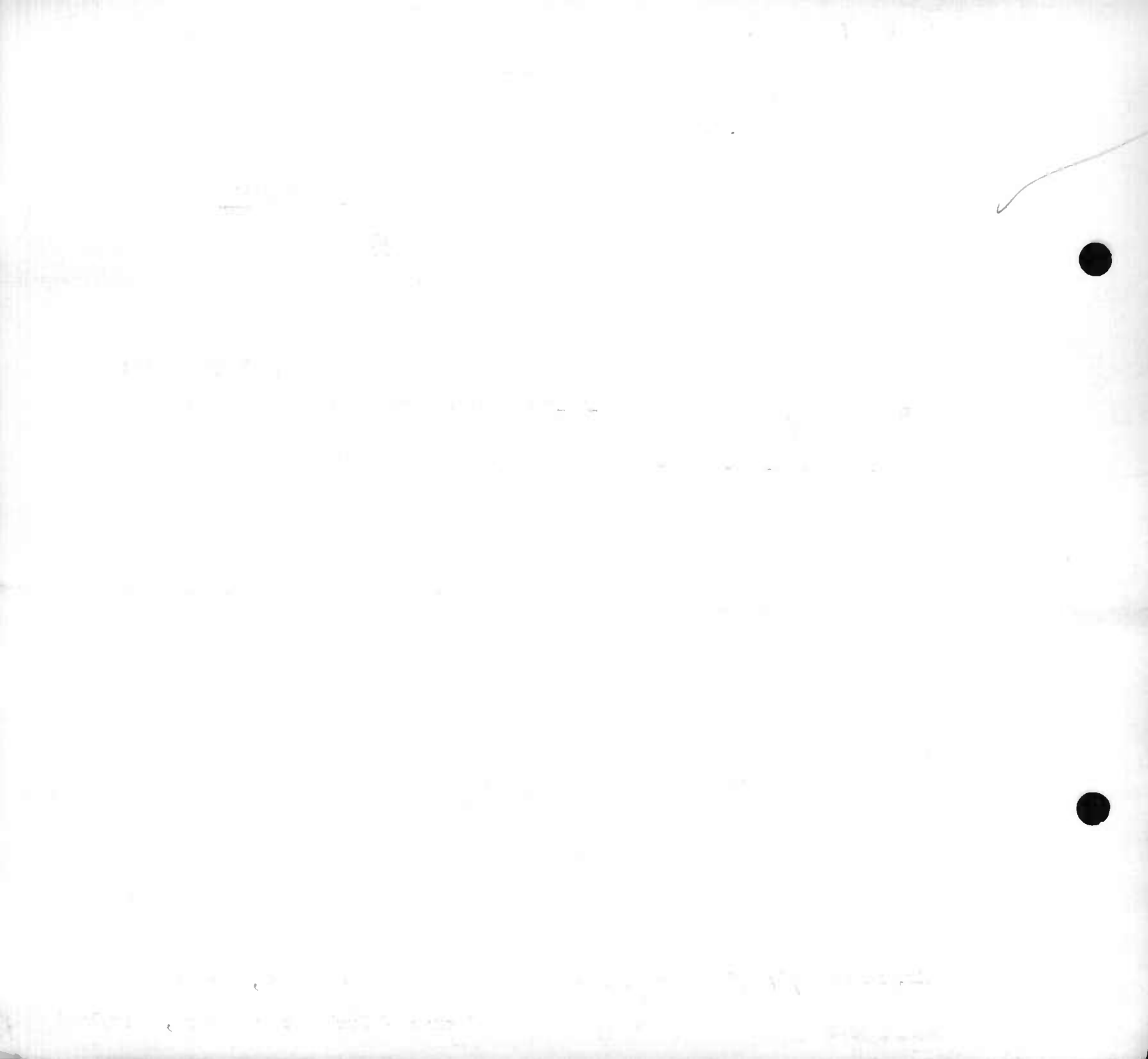
Student V. [unclear]  
[unclear] [unclear]  
[unclear] [unclear]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-614 70 00538		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00538	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TRIPLETT, GRACE Evelyn</b>		2. DATE AND HOUR OF DEATH <b>15 JAN 1970 8 15 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital 38</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INTERVIEWER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Employment Security</b>		8. DATE OF BIRTH <b>12/14/1906</b>	
13. FATHER'S NAME <b>William Woods</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Davis</b>		9. AGE (in years last birthday) <b>62</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>203-18-5038</b>		17. INFORMANT <b>Mr Shewell R Triplett</b> Same	
18. <b>225.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Recurrent C Fungal Meningitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10/24/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> 19 <b>69</b> to <b>1/15</b> 19 <b>70</b> that (I) last saw the deceased alive on <b>1/15</b> 19 <b>70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward R. Wayne</b>		23B. DATE SIGNED <b>15 Jan 70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Edward R. Wayne</b>		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Interment</b>		24B. DATE <b>1/17/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Maryland</b>			



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

J.  
SAMUEL CUNNINGHAM2. DATE  
OF  
DEATHKnown ☐Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

46 LUTHERAN HOSPITAL

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD January 14, 1970

7:00 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

6. SEX

Male

7. RACE

White

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

CATONSVILLE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

MAR. 11, 1908

10. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

112 Paradise Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

SAMUEL CUNNINGHAM

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CUSTODIAN

14B. KIND OF BUSINESS OR INDUSTRY

High school

15. MOTHER'S MAIDEN NAME

FLORA EVANS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL  
SECURITY NO.

217-10-4936

18. INFORMANT

ADDRESS

Mrs. John R. Alderton RT 2 Williams Rd 21502

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

1/17/70

24C. NAME of CEMETERY or CREMATORY

MARY Dale Cem.

24D. LOCATION (City, town, or county)

Cumberland

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

E. J. McHale

ADDRESS

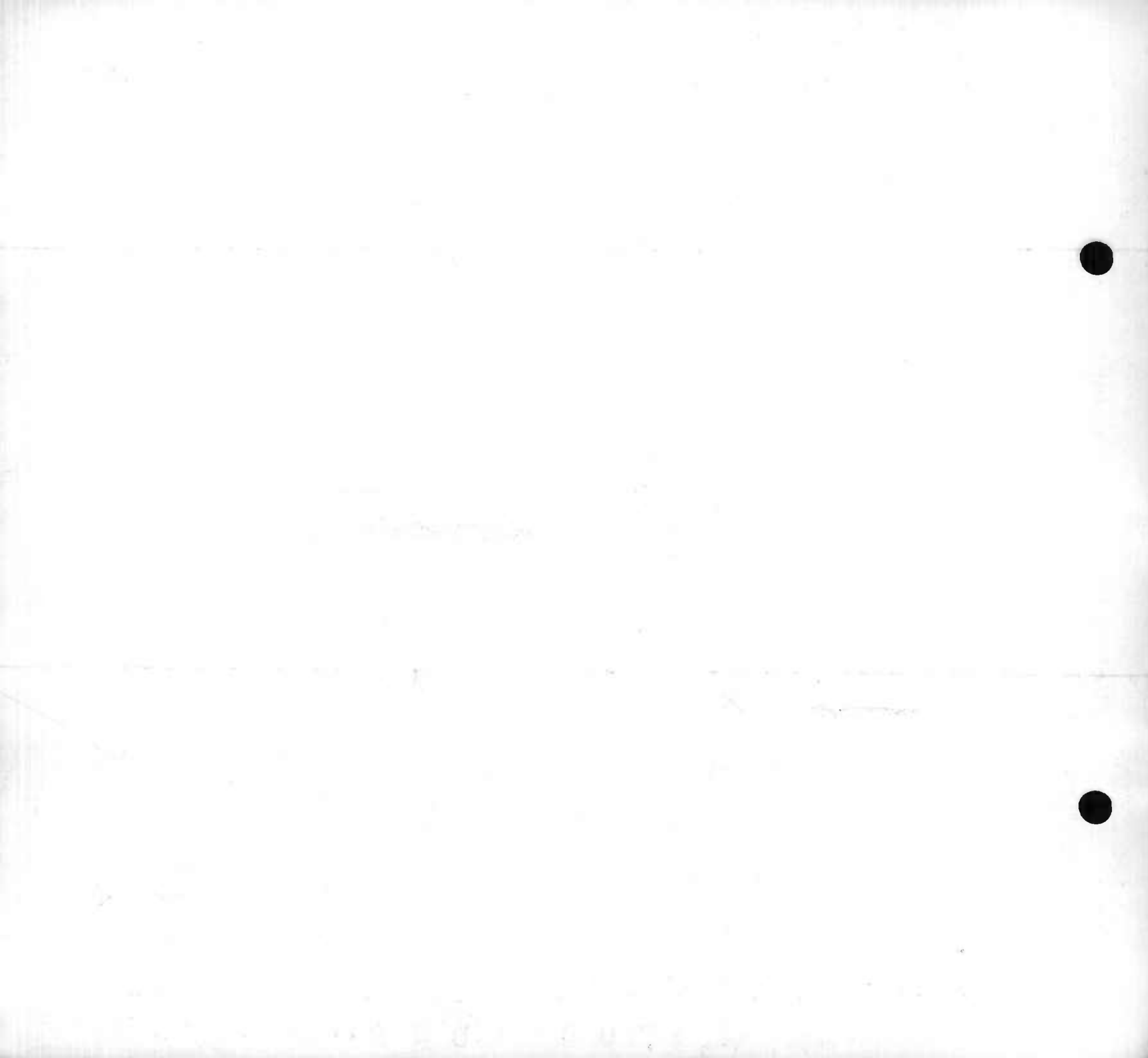
301 Frederick Rd  
Balt. Md. 21228

*Paul M. White*

Hard Date Cor.

RELEASED 4  
MEDICAL EXAM  
CAN BE  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

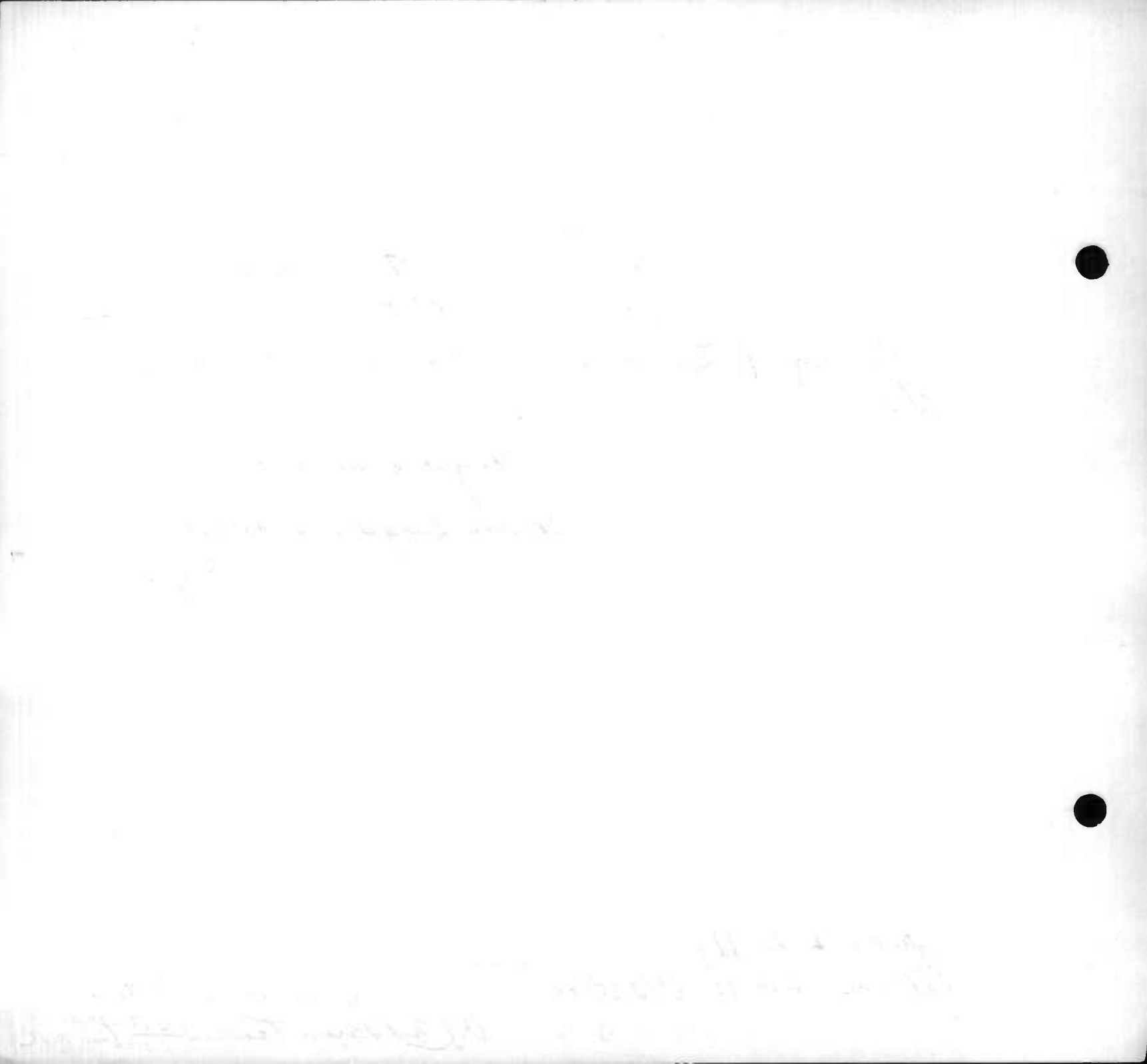
5-200		70 00510		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00540	
BIRTH NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) PETER SAWICKI SR. (SAWECKE)		2. DATE AND HOUR OF DEATH 1-8-70		11:55 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 105					
FULL NAME OF HOSPITAL OR INSTITUTION CITINCA HOME & HOSPITAL 100 N. BROADWAY ST		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 323 S. COLLINGTON ST. (311)							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE RET.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SAWICKI		14. MOTHER'S MAIDEN NAME MAGALENA LAWOWSKI					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217 261168		17. INFORMANT DAUGHTER		ADDRESS SAME AS PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E880X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ADAMS-STOKES SYNDROME		CAUSE OF DEATH (A) IMMEDIATE CAUSE Auto Respiratory Failure Few min. DUE TO, OR AS A CONSEQUENCE OF: (B) <del>FX C6 C7</del> DUE TO, OR AS A CONSEQUENCE OF: (C) FX C6 C7 Dislocation 22 Days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 323 S. COLLINGTON AVE			
21D. TIME OF INJURY (Approx.) Dec 18 1969		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell off stairs			
22. I certify that (I) (this hospital) attended the deceased from 12-18 1969 to 1-8 1970 and that (I) (we) last saw the deceased alive on 1-8 1970 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ricardo M. Thason MD		23B. DATE SIGNED 1-8-70			
23C. PHYSICIAN'S NAME (Type) RICARDO M. THASON MD		23D. ADDRESS 100 N. BROADWAY ST.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/12/70		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		24D. LOCATION (City, town, or county) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Karpowicz & F 7		ADDRESS 2525 Fleet St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00541	
BIRTH NO. 8-536 70 00541		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIRGIL L. SNYDER		2. DATE AND HOUR OF DEATH 1/15/70 7 30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Balt. Co. 53-00 C. CITY OR TOWN PIT DENIX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER GLENHEIM ROAD			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/03/97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Henry A Snyder		14. MOTHER'S MAIDEN NAME Laura C. Shopper			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 287-03-9086		17. INFORMANT ADDRESS ROBERT SNYDER, CANTON OHIO	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart Failure Chronic Lung Dis + ASCVD Q.Y.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/6 19 70 to 1/15 19 70 that (I) (we) last saw the deceased alive on 1/15 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anne L. Leddy		23B. DATE SIGNED 1/15/70		23C. PHYSICIAN'S NAME (Type) Anne L. Leddy	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-19-70		24C. NAME OF CEMETERY or CREMATORY Westlawn	
24D. LOCATION (City, town, or county) Canton Ohio		25A. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25B. ADDRESS		25D. ADDRESS		25E. ADDRESS	





1

A-156

70 00542

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00542

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BENJAMIN APANARICH

2. DATE  
OF DEATHKnown ☐ Month Day Year Hour  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

817 W. Lombard Street

3. DATE  
PRONOUNCED DEADMonth Day Year Hour  
January 14, 1970 10:50 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY 1803

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

3/28/1903

10. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

817 W. Lombard Street

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stanislaw Apanarich

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Leadman

14B. KIND OF BUSINESS OR INDUSTRY

Merchant Marine

15. MOTHER'S MAIDEN NAME

Mary Sarpolis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

216-05-3651

18. INFORMANT

Mrs. Adelaide Chasis 927 Leeds Ave.

19.

571.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Cirrhosis of liver  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

3/27

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ + Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 15, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/17/70

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cem.

24D. LOCATION (City, town, or county) (State)

New Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1970

25B. NAME OF REGISTRAR

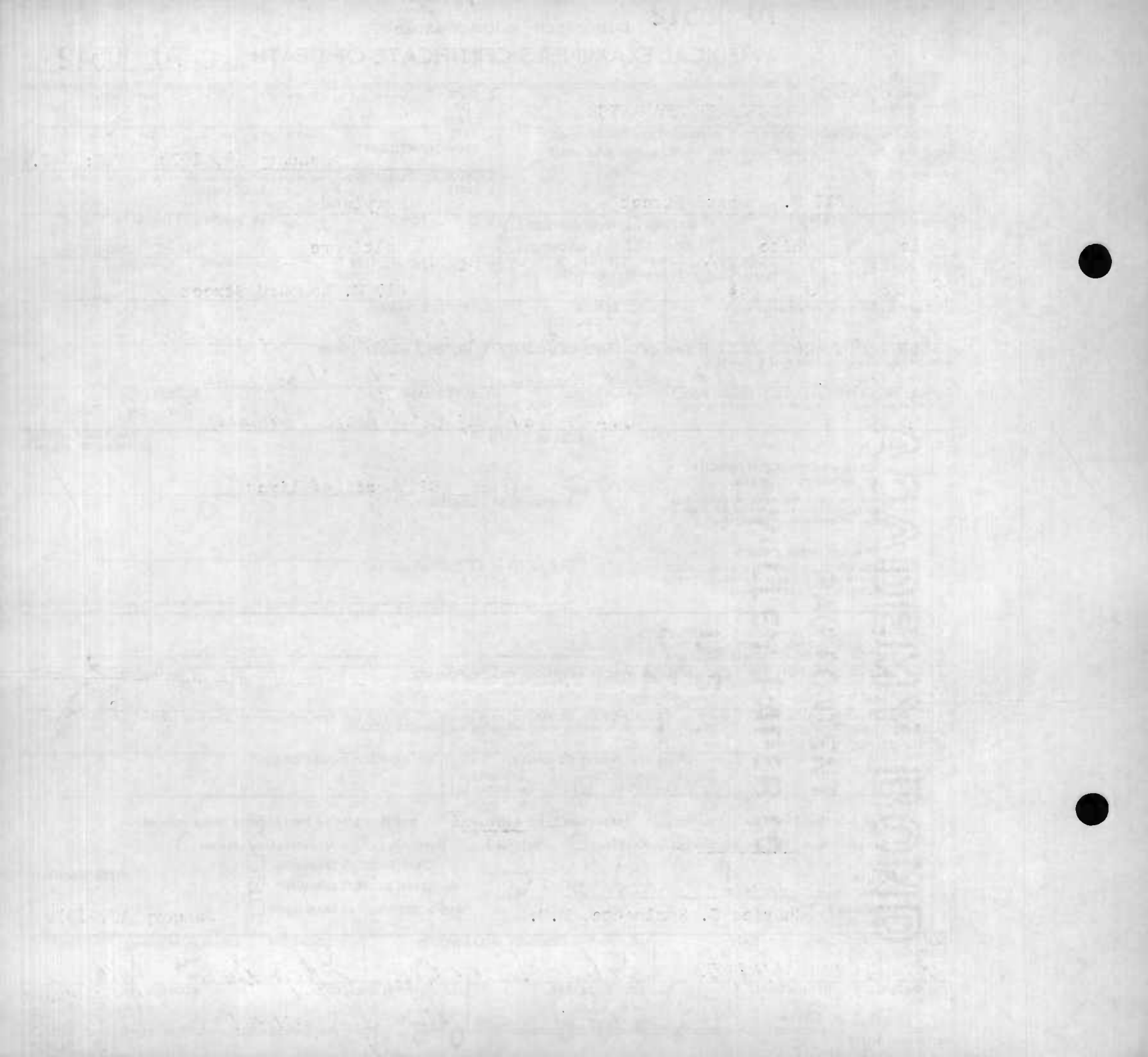
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John J. Corcoran &amp; Son, Inc.

ADDRESS

901 Hoffman St.  
23, Md.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-625		70 00543		BALTIMORE CITY HEALTH DEPARTMENT		70 00543	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Theodore Chorgan				1-11-70 5:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals				Maryland Harford			
4940 Eastern Ave.				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
31 Baltimore, Md. 21224				Aberdeen Md. 21001 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER							
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-11-20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
CARPENTER HELPER		BUILDING		49		Michigan	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
USA				Walter CHARIZAN			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Josephine unk.				16. SOCIAL SECURITY NO. 370-18-4154			
17. INFORMANT				18. CAUSE OF DEATH			
4940 Eastern Ave. ADDRESS				571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
BCH Records: Baltimore, Md. 21224				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis			
				(B) Cirrhosis with Ascites DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2			
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
				Right Supra-hilar mass			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No		No		No			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
No							
22. I certify that (1) (this hospital) attended the deceased from 1/11/70 to 1/11/70 that (1) (we) last saw the deceased alive on 1/11/70 and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Edward J. Lee MD				1/10/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Edward J. Lee Md.				Baltimore City Hospitals			
				4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		JAN. 15 1970		ANGEL HILL CEM.		HAYRE DE GRACE, HARFORD MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 19 1970		Robert E. Faber, R.D.		William Mitchell		Harford Grace, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

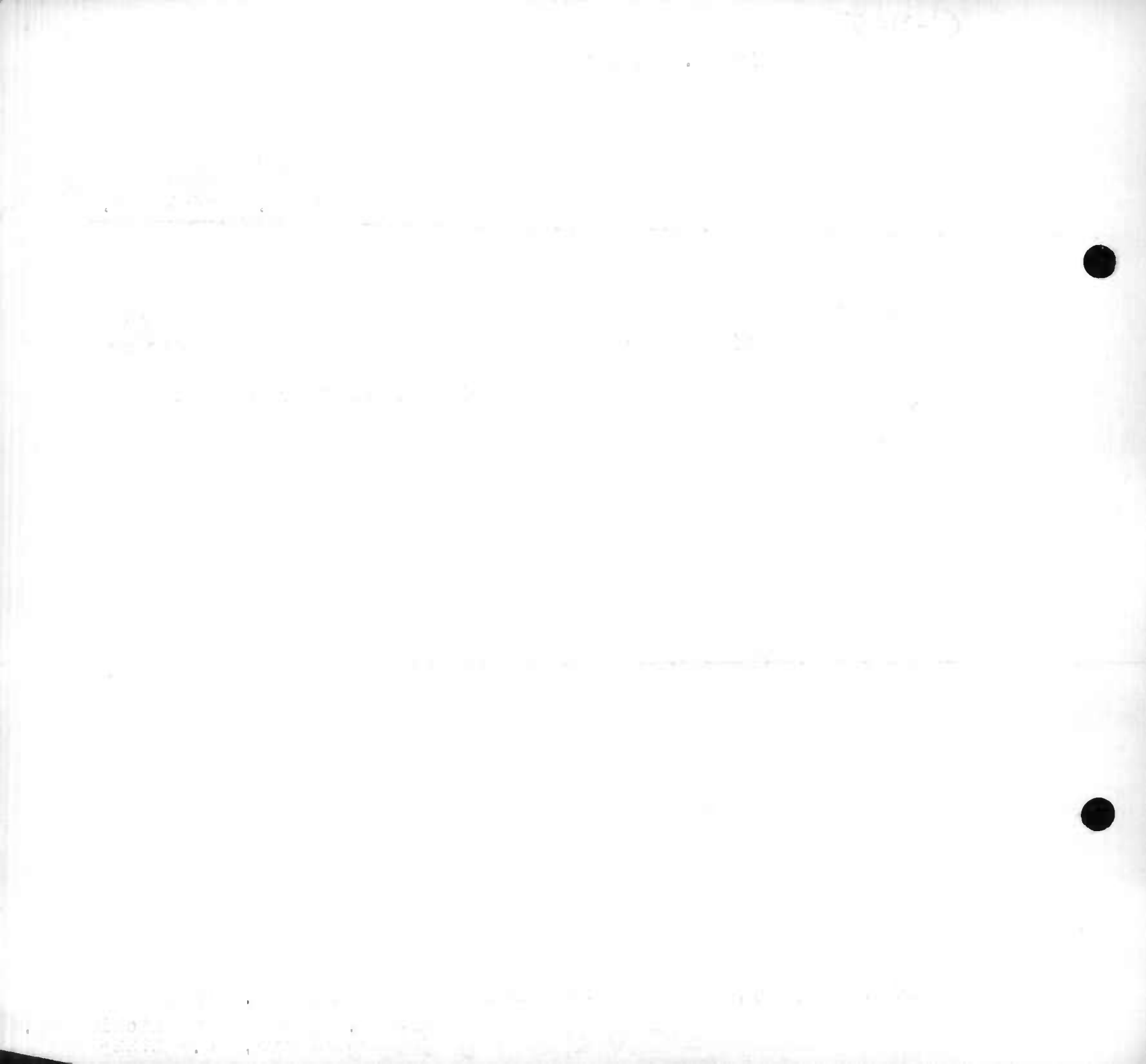
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00544</u>	
<div style="display: flex; justify-content: space-between;"> <span>W-422</span> <span>70 00544</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <b>EDWARD WALUKAS</b>			2. DATE AND HOUR OF DEATH <b>1-16-70</b> <span style="float: right;"><u>11:15 A.</u> M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1340 Glyndon Avenue Baltimore, Md. 21223</b>			A. STATE <b>1340 Glyndon Ave.</b>		<b>2102</b>
			B. COUNTY		
			C. CITY OR TOWN <b>Baltimore City</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1340 Glyndon Avenue</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-03</b>	9. AGE (In years lost birthday) <b>66 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Attendant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
13. FATHER'S NAME <b>Andrew B. Walukas</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Eva Paukstaitis</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-05-9102</b>		17. INFORMANT ADDRESS <b>Mrs. Helen A. Klainotas 1340 Glyndon Ave.</b>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1B. <u>330.4 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Embolism</u></p> <p>(B) <u>Muscular Dystrophy</u></p> <p>(C) _____</p> </div> <div style="width: 5%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>1 week</u></p> <p><u>6 years</u></p> </div> </div>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>69</u> to <u>1/16</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John P. Urlock Jr</u>				23B. DATE SIGNED <u>1/16/70</u>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN P. URLOCK, JR</b>				23D. ADDRESS <b>1227 WASHINGTON BLVD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-19-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore City Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <b>H. H. HUBBARD FUNERAL HOME 4105 Wilkens Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-265 70 00545		BALTIMORE CITY HEALTH DEPARTMENT	
<b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00545	
BIRTH NO. <u>Edith G. Cochran</u>		DATE AND HOUR OF DEATH <u>1-15-70 8:35 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>EDITH G. COCHRAN</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital 43</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2404</u>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		E. STREET AND NUMBER <u>135 E. Randall St. 135 E. Randolph St.</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		8. DATE OF BIRTH <u>5-30-91</u> 9. AGE (in years last birthday) <u>78 yrs.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horatio Cameron Houston Cameron</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jackson Mangant</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>MISS Grace Cochran</u>	
17. INFORMANT <u>Miss Grace Cochran</u>		ADDRESS <u>Same</u>	
18. <u>412.41</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>H.T. bleeding probably</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF: <u>20 Pepsic ulcer</u>	
ANTECEDENT CAUSES		(B) <u>Cerebro-vascular accident</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
(C) <u>Arteriosclerotic Cardiovascular Disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-14</u> 19 <u>70</u> to <u>1-15</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-15</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Virginia Y. Faust, M.D.</u>		23B. DATE SIGNED <u>1-15-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA Y. FAUST, M.D.</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECD. IN HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>George J. Gonce</u>	
25C. FUNERAL DIRECTOR <u>Baltimore, Md.</u>		25D. ADDRESS <u>4001 Ritchie Hgy. 21225</u>	





H-500

70 00546

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00546

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE F. HEIM</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 16, 1970</b> 9:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1970</b> 9:30 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Glen Burnie</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>Aug. 24, 1928</b>	10. AGE (In years lost birthday) <b>41</b>	E. STREET AND NUMBER <b>Rt. #1 Box 304M Stone Haven Drive</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF <b>U.S.A.</b>	13. FATHER'S NAME <b>Charles Heim</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patrolman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Police Dept.</b>	
15. MOTHER'S MAIDEN NAME <b>Myrtle Lupcus</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>Mrs. Rosemary Heim</b>	
18. INFORMANT <b>Same</b>			
19. <b>E 814.7</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>5600 blk. O'Donnell St - (cut-off)</b>		22F. HOW DID INJURY OCCUR? <b>Police officer standing at rear of his car when struck by a station wagon and that on this basis, death in my opinion</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1-16-70 about 8:00 A. M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1/20/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>George E. J. Gonce, M.D.</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>	

Office of the Director of the Bureau of Plant Industry

W. A. DILLON

*[Handwritten Signature]*

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 00547			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) Charles J. SHERBERT						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 15, 1970					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1708 Light Street						3. DATE PRONOUNCED DEAD January 15, 1970 2:00 P.M.					
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2303											
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH July 21, 1905		10. AGE (In years lost birthday) 65 64		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 1708 Light Street			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker						14B. KIND OF BUSINESS OR INDUSTRY Jenkins Funeral Home					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No						17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Matilda Stewart			
18. INFORMANT Ethel Sherbert- 518 S. Hanover St. 21230						ADDRESS					
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.41 Arteriosclerotic cardiovascular disease						CAUSE OF DEATH Arteriosclerotic cardiovascular disease					
20. DATE OF OPERATION						21. AUTOPSY? (Yes or No) Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						22D. TIME OF INJURY (Month) (Day) (Year) (Hour)					
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Isidore M. Malakis, M.D.						DATE SIGNED January 16, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 1-19-70		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970						25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully, 130 E. Fort Ave. Balto. Md. 21230			

MEDICAL EXAMINATION CERTIFICATE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

BY: \_\_\_\_\_

FOR: \_\_\_\_\_

REASON: \_\_\_\_\_

RESULT: \_\_\_\_\_

REMARKS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

STAMP: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

BY: \_\_\_\_\_

FOR: \_\_\_\_\_

REASON: \_\_\_\_\_

RESULT: \_\_\_\_\_

REMARKS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

STAMP: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

BY: \_\_\_\_\_

FOR: \_\_\_\_\_

REASON: \_\_\_\_\_

RESULT: \_\_\_\_\_

REMARKS: \_\_\_\_\_

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
W-160 70 00548					REG. NO. 70 00548				
BIRTH NO. [REDACTED]					1. NAME OF DECEASED (Type or Print) <u>Henry H. WEBER</u>				
2. DATE AND HOUR OF DEATH <u>Jan 14, 1970</u> <u>11:05</u> A.M.					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
<u>31 B C H. 4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>					<u>Md.</u> <u>2608</u>				
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>11-2-1899</u> 9. AGE (In years last birthday) <u>70</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>					11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				
13. FATHER'S NAME <u>Henry Weber</u>					14. MOTHER'S MAIDEN NAME <u>Mary ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>21201 6736</u>				
17. INFORMANT <u>Wife</u>					ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>				
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH <u>Respiratory infection</u>				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>COPD = Vanishing lung-</u>				
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Old myocardial infarction</u>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) <u>undetermined</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Dec 18, 1969</u>				
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> <u>1969</u> to <u>Jan 14</u> <u>1970</u>					that (I) (we) last saw the deceased alive on <u>Jan 13</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Mutlu Atagün</u>					23B. DATE SIGNED <u>1-14-1970</u>				
23C. PHYSICIAN'S NAME (Type) <u>DR. MUTLU ATAGÜN</u>					23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Maryland 21224</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>1/17/70</u>				
24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>					25B. NAME OF REGISTRAR <u>John E. Morda, Inc.</u>				
25C. FUNERAL DIRECTOR					ADDRESS <u>3000 E. Baltimore St.</u>				

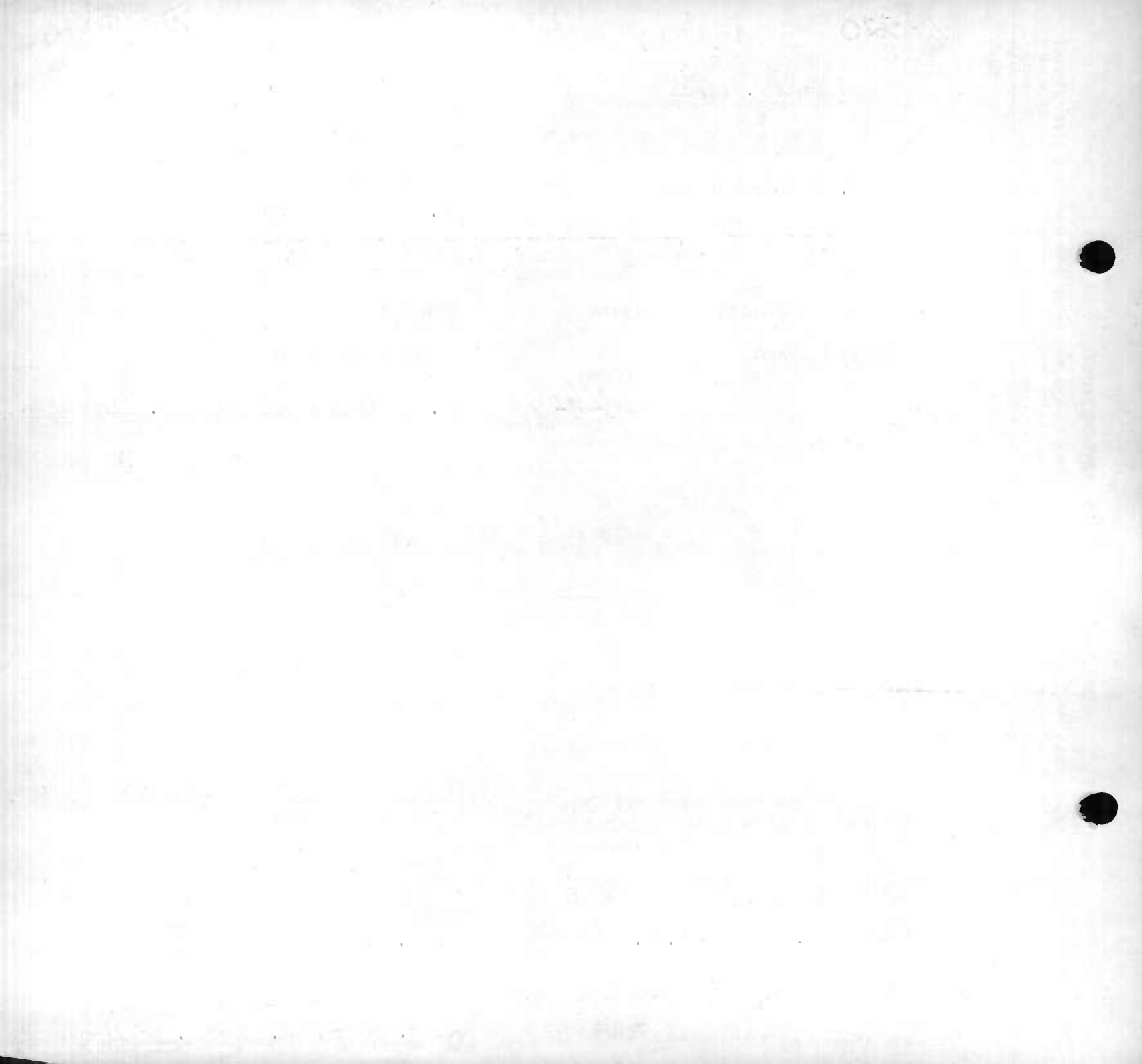




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00549</span>	
<p><b>L-520</b> <b>70 00549</b></p> <p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Thomas E. Lynch</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>January 12, 1970</i></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>8 N. Kenwood Avenue</i></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>602</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>8 N. Kenwood Avenue</i></p>			
<p><b>5. SEX</b> <i>M</i></p>	<p><b>6. RACE</b> <i>W</i></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <i>12/10/184</i></p>	<p><b>9. AGE</b> (In years lost birthday) <i>85</i></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Wholesale Millinery</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Stockman</i></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i></p>		<p><b>13. FATHER'S NAME</b> <i>Michael Lynch</i></p>			
<p><b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Lizette Regner</i></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>			
<p><b>16. SOCIAL SECURITY NO.</b> <i>275-05-4994</i></p>		<p><b>17. INFORMANT</b> <i>Mrs. Christina Getchell</i> ADDRESS <i>8 N. Linwood Ave.</i></p>			
<p><b>18. CAUSE OF DEATH</b></p>					
<p><b>I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> <i>Chronic Pulmonary Ob. Disease</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(C)</b> DUE TO, OR AS A CONSEQUENCE OF:</p>			
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b> <i>0</i></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>			
<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Dec 1965</i> <b>to</b> <i>Jan 10 1970</i>, <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 9 1970</i> <b>and that in (my) (our) opinion death occurred on the date</b> <i>Jan 12 1970</i> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <i>Charles C. MacMinn M.D.</i></p>		<p><b>23B. DATE SIGNED</b> <i>Jan 13, 1970</i></p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type) <i>Charles C. MacMinn, M. D.</i></p>	
<p><b>23D. ADDRESS</b> <i>2900 E. Baltimore Street</i></p>		<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i></p>			
<p><b>24B. DATE</b> <i>1/14/70</i></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Oak Lawn Cemetery</i></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Maryland</i></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 19 1970</i></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Taylor</i></p>		<p><b>25C. FUNERAL DIRECTOR</b> ADDRESS <i>John A. Norton, Inc. 3000 E. Baltimore St.</i></p>	



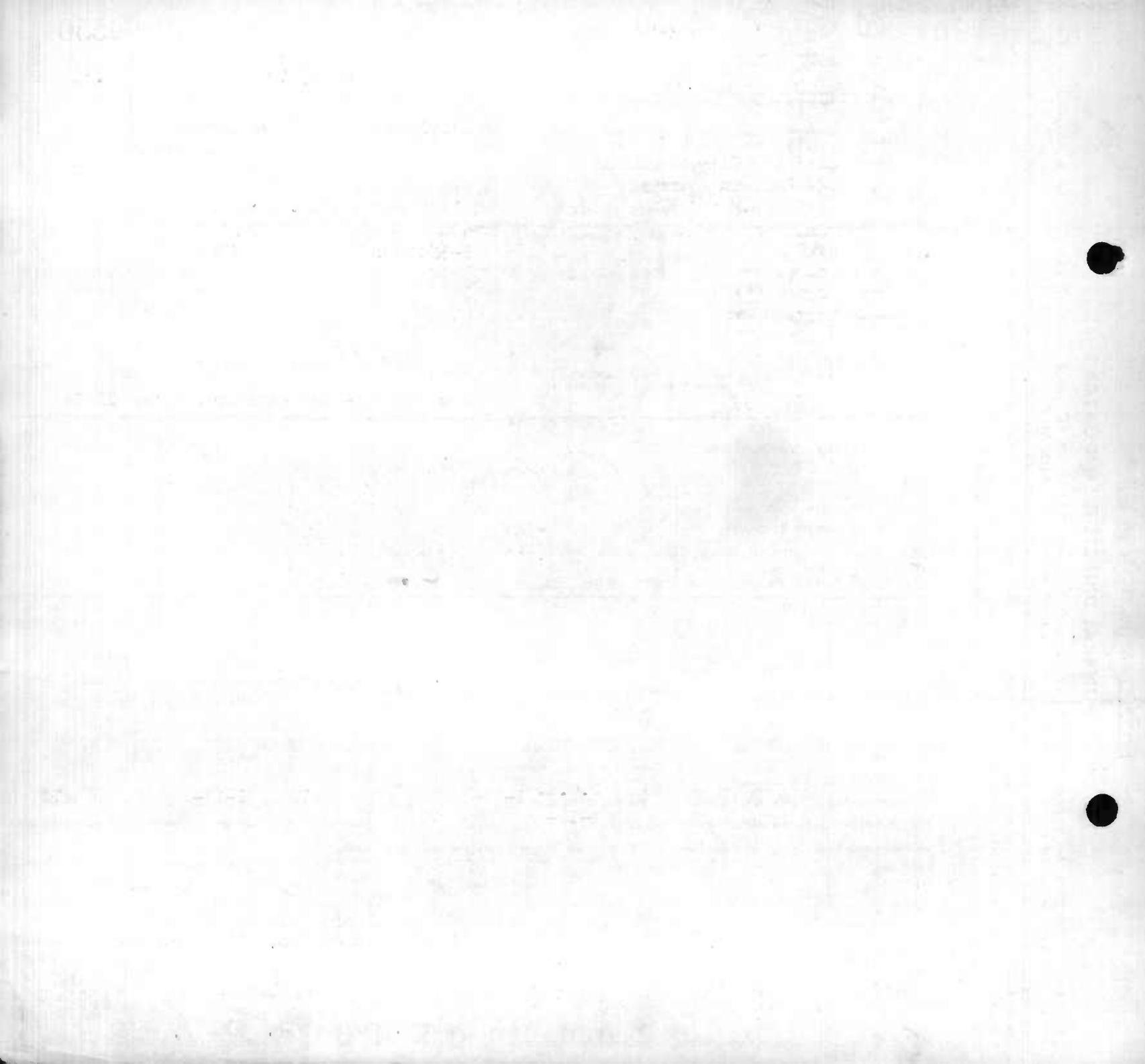


RELEASED BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 70 00550		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 00550	
1. NAME OF DECEASED (Type or Print) <i>Theodore Bielas</i>				2. DATE AND HOUR OF DEATH 1-13-1970 12.50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>1205 South 48th. Street 21222</i>							
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-19-1907</i> <i>9-13-1905</i>	9. AGE (In years last birthday) <i>62</i> <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chemical Employer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Bielas</i>				14. MOTHER'S MAIDEN NAME <i>Rose ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>WW 77</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>MYOCARDIAL INFARCTION</i> <i>CARDIOVASCULAR DISEASE</i> (B) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) .....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>MINUTES</i> <i>Year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>D.O.A.</i>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1-13-</i> <i>19 70</i> to <i>1-13-</i> <i>19 70</i> , that (I) (we) last saw the deceased alive on <i>1-13-</i> <i>19 70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arnold Levins</i> <i>MD.</i> DEGREE				23B. DATE SIGNED <i>1-13-1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Arnold Levins</i> <i>MD.</i> DEGREE	
23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Baltimore, Maryland 21224</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/16/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery, Baltimore, Maryland</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>5-400</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 00551</b>	
1. NAME OF DECEASED (Type or Print) <b>CARLOS SALA</b>		2. DATE AND HOUR OF DEATH <b>1/16/70 12<sup>30</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>8 E. PLEASANT ST. MERCY</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <b>401</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSP.</b>		C. CITY OR TOWN <b>8 E. PLEASANT ST.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/19</b>	9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>FRANK SALA</b>		14. MOTHER'S MAIDEN NAME <b>FUCITS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-65-9019</b>		17. INFORMANT <b>Chas. Swape 1605 Clarkson St.</b>	
18. <b>398 X I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MID. CEREBRAL ART. OCCLUSION</b>		<b>6d</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ATRIAL FIB + EMBOLISM</b>		<b>4w</b>	
		(C) <b>RHD</b>		<b>4w</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>70</b> to <b>1/16</b> 19 <b>70</b> and that (I) (we) last saw the deceased alive on <b>1/16</b> 19 <b>70</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Susan Salinger MD</b>		23B. DATE SIGNED <b>1/16/70</b>		23C. PHYSICIAN'S NAME (Type) <b>W. Susan Salinger MD</b>	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/19/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE RECD. BY HEALTH DEPT. <b>JAN 19 1970</b>			
25B. NAME OF REGISTRAR <b>McCarthy</b>		25C. FUNERAL DIRECTOR <b>130 E. Fort Ave.</b>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

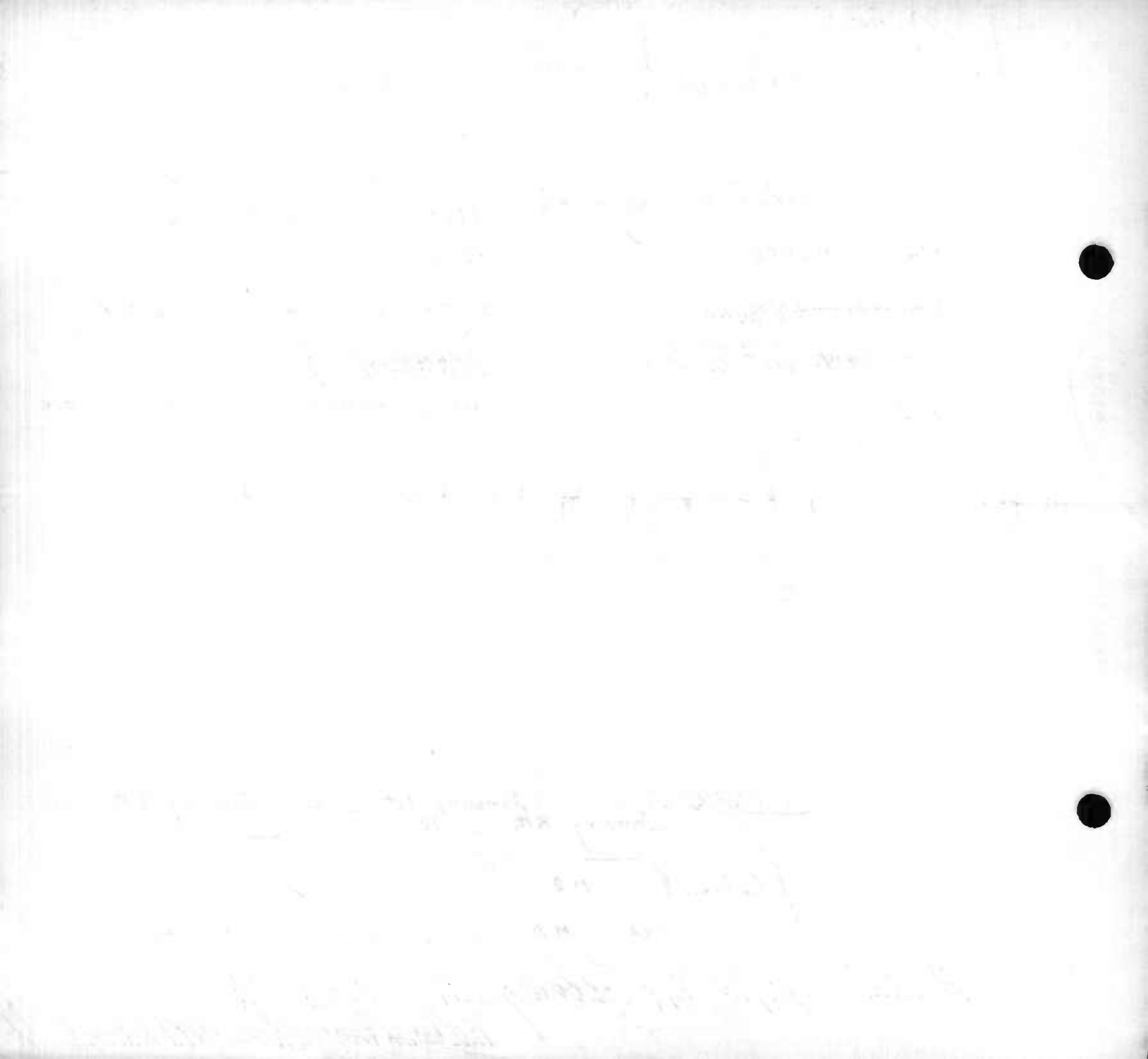
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00552</u>	
8-345 BIRTH NO.		70 00552 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DONALD STALLINGS</u>		2. DATE AND HOUR OF DEATH <u>1/14/70</u> <u>1 10 20</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>St. Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>MD</u> B. COUNTY <u>831</u>	
5. SEX <u>M</u> 6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>04-14-00</u>		9. AGE (In years last birthday) <u>69</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Drydock Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stallings</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Stucklader</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-5530</u>	
17. INFORMANT <u>Emma L. Stallings</u>		ADDRESS <u>- 2817 Pelham Ave. - 21213</u>	
18. <u>195.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE <u>Abdominal Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Probable Squamous Cell Ca Gall bladder.</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>DA</u> (this hospital) attended the deceased from <u>1/12</u> 19 <u>70</u> to <u>1/14</u> 19 <u>70</u> that <u>he</u> (we) last saw the deceased alive on <u>1/14</u> 19 <u>70</u> and that in (my) <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(he)</u> (did) <u>(did not)</u> view the body after death.			
23A. SIGNATURE <u>Karl R. Meach, Jr., M.D.</u>		23B. DATE SIGNED <u>1/14/70</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>Valerie F. Taylor</u>	
25C. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>		ADDRESS <u>415 Belair Rd. - 21206</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-254		70 00553		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00553	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MCMILLAN, ANGELIO</b>				2. DATE AND HOUR OF DEATH <b>January 8th, 1970 6 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>				A. STATE <b>MARYLAND</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>907</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1765 GORSUCH AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-12-08</b>	9. AGE (in years last birthday) <b>61</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED/Reporter</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Brook McMillan</b>			14. MOTHER'S MAIDEN NAME <b>Rachel ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>HILL CADRIN</b>		ADDRESS <b>same as above</b>
18. <b>0119 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>ACUTE COR PULMONALE</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>PULMONARY TUBERCULOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>P</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 1st 1970</b> to <b>January 8th 1970</b> that (I) (we) last saw the deceased alive on <b>January 8th 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Cabrera V.</b>				M.D. DEGREE <b>M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>JUAN CABRERA</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/70</b>		24C. NAME of CEMETERY or CREMATORY <b>McCalver Cemetery</b>		24D. LOCATION <b>Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Calder E. Calder</b>		25C. FUNERAL DIRECTOR <b>William J. Turner</b>		ADDRESS <b>319 N. Howard St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-423		70 00554		CERTIFICATE OF DEATH		REG. NO. 70 00554	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ALSTON, LILLIE C.</b>			
2. DATE AND HOUR OF DEATH <b>1-13-1970 10:30 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2002</b>				5. STREET AND NUMBER <b>2522 W BALTIMORE ST.</b>			
6. CITY OR TOWN <b>BALTIMORE</b>				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. SEX <b>F</b> 9. RACE <b>N</b> 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. DATE OF BIRTH <b>5-12-1933</b> 12. AGE (In years last birthday) <b>36</b>			
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>				14. BIRTHPLACE (State or foreign country) <b>S.C.</b>			
15. FATHER'S NAME <b>Major Kennedy</b>				16. MOTHER'S MAIDEN NAME <b>Emma Williams</b>			
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				18. SOCIAL SECURITY NO. <b>244-82-3710</b>			
19. INFORMANT <b>James Alston</b>				20. ADDRESS <b>2522 W. Baltimore St.</b>			
21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>410.9 I</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory Failure</b> (B) PULMONARY EMBOLISM (C) MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mins.</b> <b>25 mins.</b> <b>30 mins.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
21A. DATE OF OPERATION <b>2</b>				21B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. HOW DID INJURY OCCUR?			
21E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>1-8-1970</b> to <b>1-13-1970</b> , that (I) (we) last saw the deceased alive on <b>1-13-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Prem Lal M.B., B.S.</b>				23B. DATE SIGNED <b>1-13-1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>PREM LAL. M.B., B.S.</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTIMORE MD. 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Shipped</b>				24B. DATE <b>1/17/70</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Winnsboro S.C.</b>				24D. LOCATION (City, town, or county) (State) <b>Winnsboro S.C.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>				25B. NAME OF REGISTRAR <b>John E. Fisher</b>			
25C. FUNERAL DIRECTOR <b>William James Kane</b>				25D. ADDRESS <b>39 N. Schroeder St.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

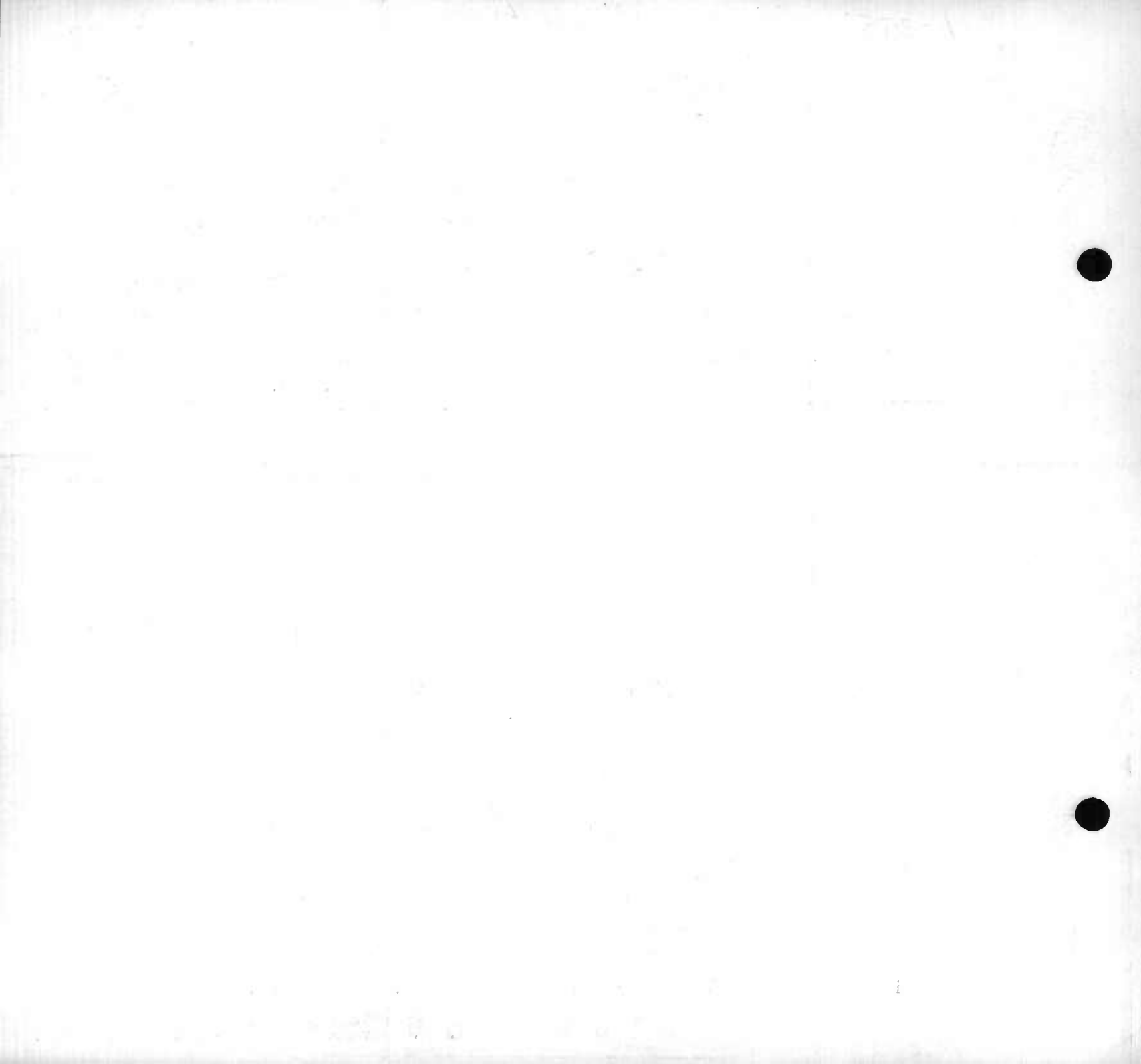
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-300		70 00555		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00555	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>FANNIE S. DOWDY</b>			
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>January 15, 1970 3:30 P.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2798</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9-19-09</b>		9. AGE (In years last birthday) <b>60</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Will Burrell</b>				14. MOTHER'S MAIDEN NAME <b>Queen</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ray F. Broome</b>	
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A SCVD and hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pneumonia</b>						<b>10 DAYS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>12-31-1969</b> to <b>1-15-1970</b> that (I) (we) lost saw the deceased alive on <b>1-15-1970</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Alberto Angulo M.D.</b>				23B. DATE SIGNED <b>1-15-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Alberto Angulo, M.D.</b>	
23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Airy</b>		24D. LOCATION (City, town, or county) (State) <b>Chesapeake</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>John E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Chesapeake [unclear]</b>		ADDRESS <b>Chesapeake [unclear]</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

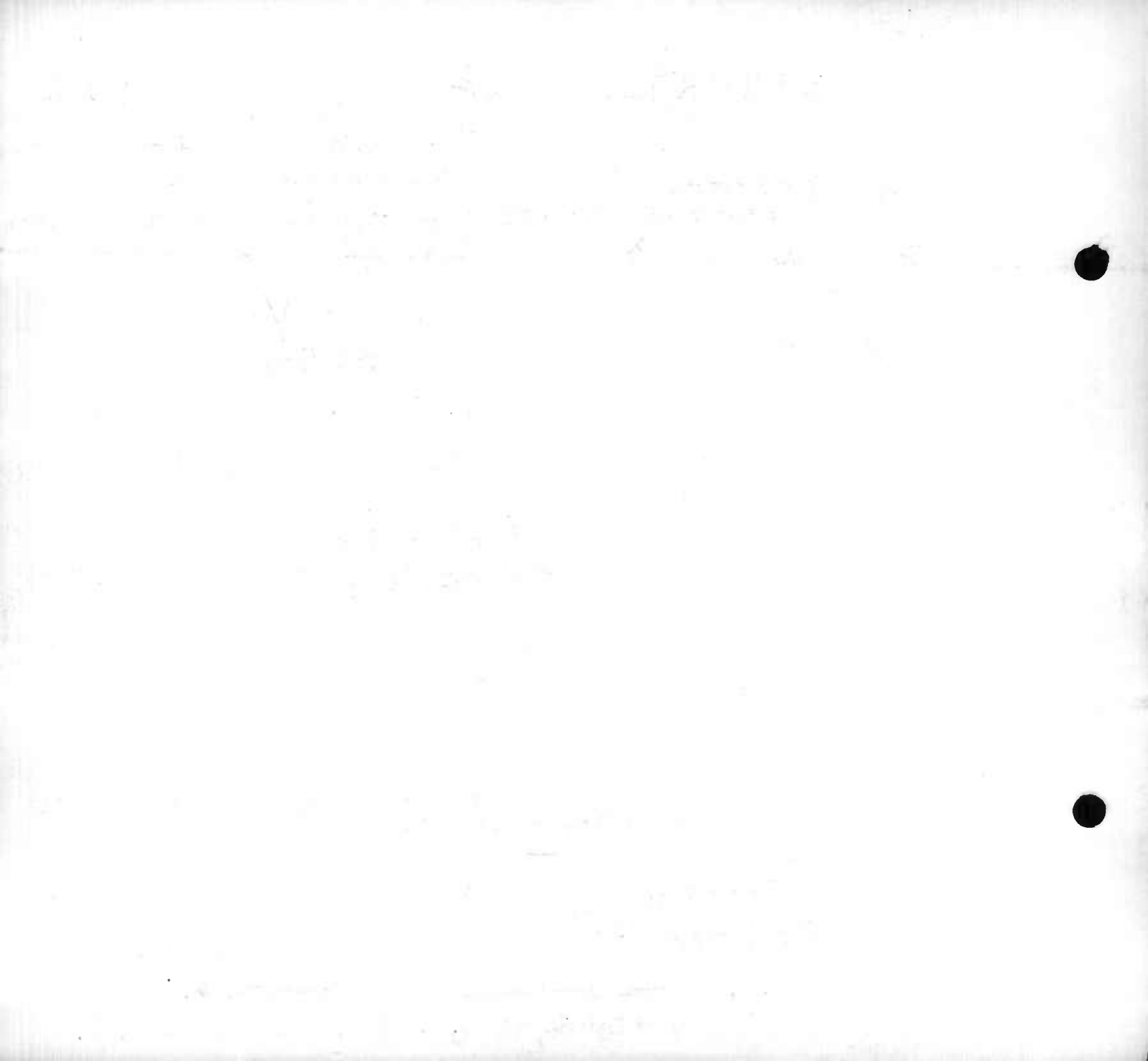
L-355		70 00556		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00556	
BIRTH NO. LEO		1. NAME OF DECEASED (Type or Print) James L. LAUTTMAN		2. DATE AND HOUR OF DEATH 1/13/70		5 <sup>35</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE 42				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2798 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4001 W. BELVEDERE AVE.			
5. SEX MALE	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-97	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Tavern Keeper		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William T. Lauttman				14. MOTHER'S MAIDEN NAME Emma Watts			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service UNKNOWN - YES WW I		16. SOCIAL SECURITY NO. 217 32 9256		17. INFORMANT Balto. Md. 21212 ADDRESS Mrs. Edith M. Hudson 115 Dunbarton Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 600 X I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: (C) SUPRACARDIAL PROSTATECTOMY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours. 5 hours.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 1-13-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/11 1970 to 1/13 1970 that (I) (we) last saw the deceased alive on 1/13 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leslie Abramowitz M.D. DEGREE				23B. DATE SIGNED 1/13/70		23C. PHYSICIAN'S NAME (Type) LESLIE ABRAMOWITZ M.D. DEGREE	
23D. ADDRESS SINAI HOSPITAL OF BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 16 JAN 70		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Ceme.		24D. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 4611 Park Hgts. Av.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 00557	
BIRTH NO. 8-363		70 00557	
1. NAME OF DECEASED (Type or Print) <b>STUERTZ MINA</b>		2. DATE AND HOUR OF DEATH <b>1-17-70 11:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>48 53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> <b>42 BALTIMORE MARYLAND</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>306 High Falcon Rd Reisterstown</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		8. DATE OF BIRTH <b>1-26-08</b> 9. AGE (In years last birthday) <b>61</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>Arthur Buehler</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>xxxxxxx Unknown</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mrs. Christa D. Wysham Reisterstown, Md</b>	
18. <b>182.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-Resp Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bilateral Bronchopneumonia</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Ca of Uterus Stage IV</b>	
		(C) <b>10 days</b> <b>12 weeks</b> <b>2 months</b> <b>(documented)</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-16-70</b> 19 <b>70</b> to <b>1-17-70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1-15-70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>P.B. Denovan</b>		23B. DATE SIGNED <b>1-17-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>P.B. Denovan</b>		23D. ADDRESS <b>SINAI Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 20, 70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>		24D. LOCATION (City, town, or county) (State) <b>HOWARD CO., MD.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>J. H. Ely &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

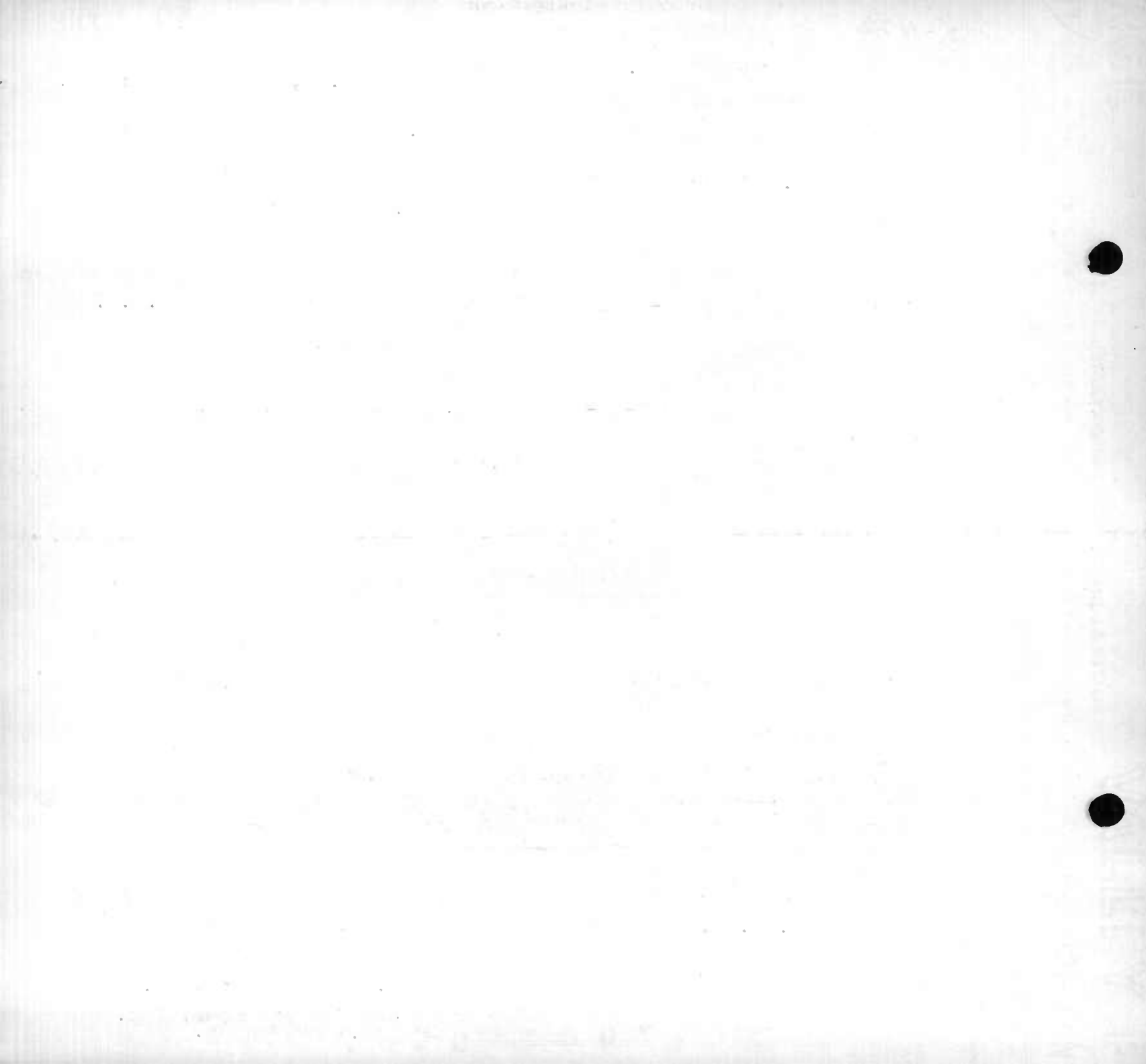
R-253		70 00558		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00558	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Henry Robert Rosenthal</u>				2. DATE AND HOUR OF DEATH <u>JAN. 13, 1970</u> <u>7:45</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7938 Sinclair Lane</u> <u>21222</u> <u>005</u>					
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-17-97</u>		9. AGE (In years lost day) <u>72</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Dealer</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry August Rosenthal</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thillman</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Army WWI</u>				16. SOCIAL SECURITY NO. <u>217-18-2536</u>		17. INFORMANT <u>BCH Records:</u> ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
18. <u>15411</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Insufficiency</u> (B) <u>Acute Bronchopneumonia</u> (C) <u>Carcinoma of rectum</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>1 wk</u> <u>?</u>	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1-11-70</u> to <u>1-13-70</u> that (I) (we) lost saw the deceased alive on <u>JAN 13</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Kenneth C. Gertsen MD.</u>				23B. DATE SIGNED <u>1-13-70</u>					
23C. PHYSICIAN'S NAME (Type) <u>KENNETH C. GERTSEN, M.D.</u>				23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/16/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <u>1970000</u>		25C. FUNERAL DIRECTOR <u>Schulz Funeral Home, Inc.</u> <u>8334 Brehms Lane</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00559</u>
<b>BIRTH NO.</b> <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">K-452</div>		<div style="font-size: 2em; font-weight: bold;">70 00559</div> <b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>FREDERICK A. KLIMES</b>		<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><b>Jan. 14, 1970</b></span> <span><b>8:30 a.</b></span> </div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>   <div style="font-size: 1.5em;">00</div> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>   <b>512 N. Clinton Street</b> </div> </div>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.,</b> B. COUNTY <b>21205</b>  <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>7. STREET AND NUMBER</b> <b>512 N. Clinton Street</b>		
<b>5. SEX</b> <b>male</b>	<b>6. RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2/9/88</b>	<b>9. AGE</b> (In years last birthday) <b>81</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>self-employed</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Czechoslovakia</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>unknown</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>217-14-6253A</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>217-14-6253A</b>		<b>17. INFORMANT</b> <b>Dr. Louis Klimes, son,</b> <b>ADDRESS</b> <b>2412 Lake Ave.</b>		
<b>18. CAUSE OF DEATH</b>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <div style="font-size: 1.5em; font-weight: bold;">412.4 I</div> </div> <div style="width: 50%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <div style="font-size: 1.5em; font-weight: bold;">Jan 11, 1970</div> </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>ANTECEDENT CAUSES</b>  <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> </div> <div style="width: 50%;"> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <div style="font-size: 1.5em; font-weight: bold;">Cerebral Hemorrhage</div> </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>  <div style="font-size: 1.5em; font-weight: bold;">Myocardial Failure</div> </div> <div style="width: 50%;"> <b>(D) DUE TO, OR AS A CONSEQUENCE OF:</b>  <div style="font-size: 1.5em; font-weight: bold;">Arteriosclerotic C.V. Disease</div> </div> </div>				
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <div style="font-size: 1.5em; font-weight: bold;">None</div>				
<b>19A. DATE OF OPERATION</b> <div style="font-size: 1.5em; font-weight: bold;">None</div>	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <div style="font-size: 1.5em; font-weight: bold;">None</div>	<b>20A. AUTOPSY?</b> (Yes or No) <b>None</b>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <div style="font-size: 1.5em; font-weight: bold;">None</div>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>None</b>	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	<b>21C. WHERE DID INJURY OCCUR?</b> <b>None</b>	<b>(If in Baltimore City, give exact location)</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>None</b>	<b>21E. INJURY OCCURRED</b> While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b> <b>None</b>		
<b>22. I certify that (I) (the hospital) attended the deceased from</b> <b>Dec 10 1969</b> <b>to</b> <b>Jan 14 1970</b> , <b>that (I) (we) lost saw the deceased alive on</b> <b>Jan 13 1970</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <div style="font-size: 1.5em; font-weight: bold;">E. A. Schimunek M.D.</div>			<b>23B. DATE SIGNED</b> <div style="font-size: 1.5em; font-weight: bold;">1-15-70</div>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. E. A. Schimunek</b>			<b>23D. ADDRESS</b> <b>842 S. East Avenue</b>	
<b>DEGREE</b>				
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24B. DATE</b> <b>1/17/70</b>	<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Bohemian National Cem.</b>	<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Home, Inc.</b>		<b>ADDRESS</b> <b>2601 E. Madison St.</b>		



# FUNERAL DIRECTOR: IMPORTANT

017 17 69

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00560	
W-560 70 00560				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN M WEHNER		1-15-70 5:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
JOHNS HOPKINS HOSPITAL 33			MD. BALTIMORE CITY 702		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2616 ASHLAND AVE. 21205		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/11/00	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STOREROOM ATTENDANT		Crown Cork & Seal		MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
John Wehner			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
No			Gertrude Wehner nee (Maisel)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
215-05-7943-4			Marie Winkelman, 2616 Ashland Ave. 21205		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					14 days
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 5 19 70 to Jan 15 19 70 that (I) (we) last saw the deceased alive on Jan 15 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David Capuzzi, M.D.				1-15-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
David Capuzzi				Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-19-70		Gardens of Faith Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 19 1970		J. J. J. J.		Schmunk Funeral Home, 3331 Brehms Lane, 21213	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

W-416		70 00561		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 70 00561	
1. NAME OF DECEASED (Type or Print) <b>MARY W. WOOLFORD</b>					2. DATE AND HOUR OF DEATH <b>1.15.70 3.10 a.m.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore Genl Hosp.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>ANNARUNDEL 52-00</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore Genl Hosp.</b>					C. CITY OR TOWN <b>Glen Burnie</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>7481 Furnace Branch Rd</b>									
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-7-97</b>		9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Herman Amelung</b>				14. MOTHER'S MAIDEN NAME <b>Annie E Miller</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-52-9318</b>		17. INFORMANT ADDRESS <b>Mrs. Barbara Cuthbert-15 Straw Hatt Rd. Apt 3B</b>			
1B. <b>436.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro-vascular acc.</b>				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <b>Hypertension</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1.7.70</b> to <b>1.15.70</b> , that (I) (we) last saw the deceased alive on <b>1.15.70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Felix J. Martin</b>						23B. DATE SIGNED <b>1.15.70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Gabel, M.D.</b>						23D. ADDRESS <b>Loring Byers Funeral Service 8728 Liberty Rd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Ave. Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Gabel, M.D.</b>		25C. FUNERAL DIRECTOR <b>Loring Byers Funeral Service 8728 Liberty Rd</b>					

Baltimore

Housewife

217-11-1111 Mrs. Josephine (Lillian) L. L. L.

Baltimore National Bank, Frederick Ave., Baltimore, Md.

1/1/70

Total

Johns Hopkins Hospital, Baltimore, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

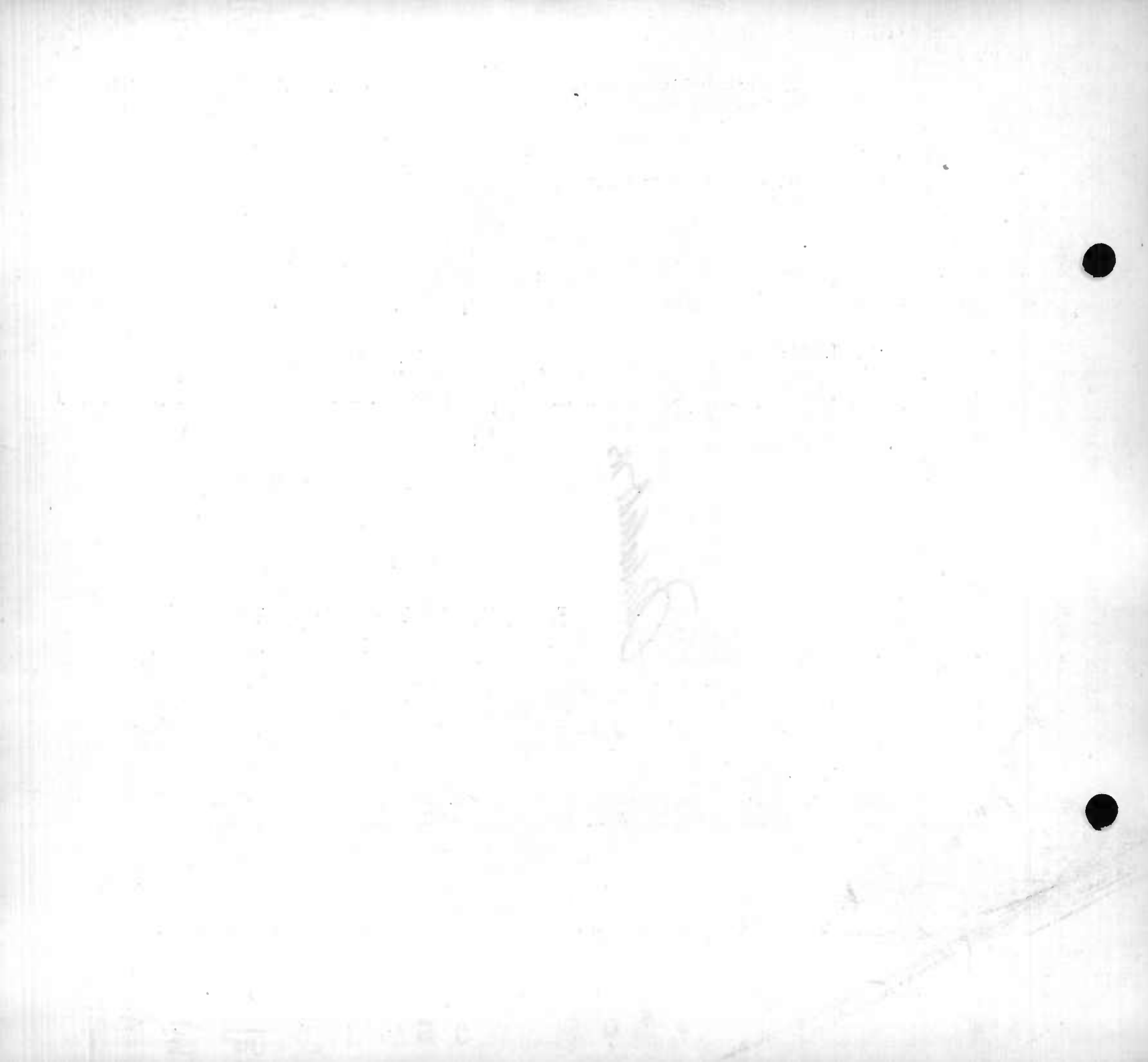
M-635 70 00562		BALTIMORE CITY HEALTH DEPARTMENT		70 00562	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>GERTRUDE J. MERTEN</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 13, 1970</u> <u>7:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2734</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u>			E. STREET AND NUMBER <u>4110 GRANITE AVENUE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>AUGUST 13, 1895</u> 9. AGE (in years last birthday) <u>74</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Hugo Merten</u>			14. MOTHER'S MAIDEN NAME <u>Lena Gluth</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>212-10-4679</u>		17. INFORMANT <u>WALTER F. MERTEN</u> ADDRESS <u>4110 GRANITE AVE. BALTO. MD.</u>
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION</u> (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (C) <u>ARTERIOSCLEROTIC HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN 5</u> 19 <u>70</u> to <u>JANUARY 13</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>JAN 13</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.			23B. DATE SIGNED <u>1-13-70</u>		23C. PHYSICIAN'S NAME (Type) <u>YU, SUI LIT</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1-16-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			25B. NAME OF REGISTRAR <u>John E. Miller</u>		25C. FUNERAL DIRECTOR <u>John E. Miller Inc. 415 Belair Rd. - 21206</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-431 70 00563		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00563
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Arthur Cooper Gladfelter</b>		2. DATE AND HOUR OF DEATH <b>Jan. 13, 1970 4:18 P M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>5719 Edmondson Ave.</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/19/93</b>	9. AGE (In years last birthday) <b>76</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>USN</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Wm. Gladfelter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cooper</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USN 1911-?</b>		16. SOCIAL SECURITY NO. <b>219-14-1551</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>
18. DISEASE OR INJURY DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>SEPSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, arising rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Sepsis</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) <b>Sacral &amp; perianal decubitus ulcer</b> <b>Status post left hip fracture</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days 1 month</b>		
19A. DATE OF OPERATION <b>12/13/69</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture left hip</b>	20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>5719 Edmondson Ave</b>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12/3/69 5:00 AM</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>fall</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2 19 69</b> to <b>Jan. 13 19 70</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 13 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Peter J. Philpott MD</b>		23B. DATE SIGNED <b>1/14/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Peter J. Philpott, Surgeon (R)</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/16/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE RECD. BY HEALTH DEPT. <b>JAN 19 1970</b>	25B. NAME OF REGISTRAR <b>000000</b>	25C. FUNERAL DIRECTOR <b>000000</b>		
ADDRESS <b>1630 Edmondson Ave., 21228</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

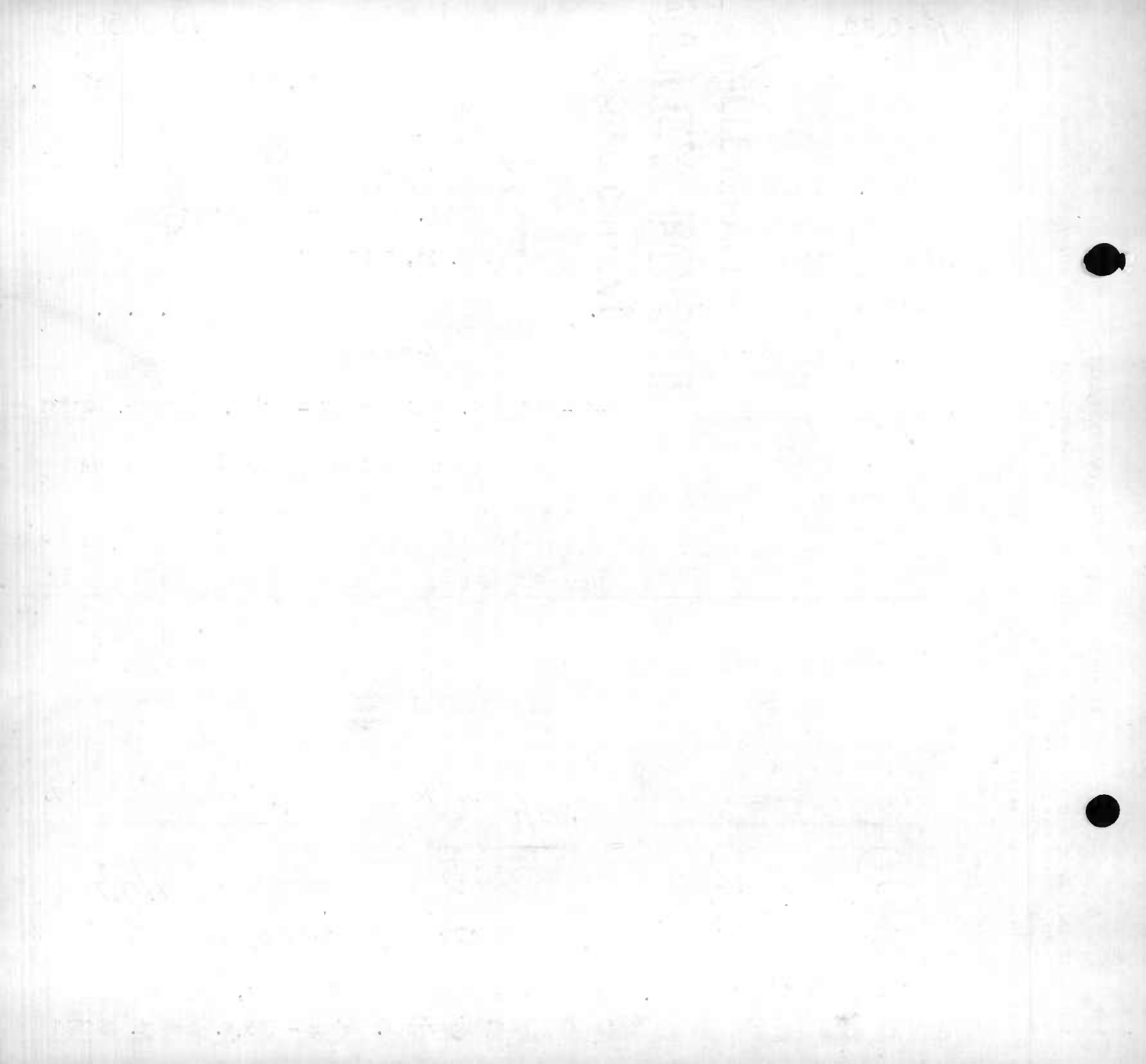
M.-250		70 00564		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00564	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MCKENNA MARGARET				2. DATE AND HOUR OF DEATH JAN 17 1970 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD B. COUNTY 1803			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 137 S. POPPLETON ST.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 OCT 1894	9. AGE (in years last birthday) 85	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Sellman				14. MOTHER'S MAIDEN NAME Mary E. Becraft			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-60-0326		17. INFORMANT Mrs. Estella Proctor, 122 Nunnery Lane		ADDRESS Apt. a	
18. 153.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) METASTATIC CARCINOMA PROBABLY LARGE BOWEL PRIMARY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ASCVD 20 YRS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1970 to Jan 17 1970 that (I) (we) lost saw the deceased alive on Jan 17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James S. Botzky M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan 17, 1970	
23C. PHYSICIAN'S NAME (Type) RONALD S. BOTZKY M.D. DEGREE				23D. ADDRESS UNIVERSITY HOSP BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/70		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR W. E. Z. K. E. 0 0 0		25C. FUNERAL DIRECTOR W. E. Z. K. E. 0 0 0		ADDRESS Edmondson Ave, Catonsville 21228	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00565	
<div style="display: flex; justify-content: space-between;"> <span>R-232</span> <span>70 00565</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Melvin Joseph Rostek		January 16, 1970		8:10 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  426 S. Wolfe Street		A. STATE Maryland		B. COUNTY 202	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 426 S. Wolfe Street #21231			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 31, 1920	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Furniture Make		Union Bros.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Rostek		Mary Yamroz		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-10-7671		Mrs. Marie Rostek - 426 S. Wolfe St. #21231	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 YR	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/12/70 to 1/16/70 that (I) last saw the deceased alive on 1/12/70 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Irvin B. Kaplan		1/17/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
IRVIN B. KAPLAN MD		129 S BROADWAY BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/20/70		St. Stanislaus Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 19 1970		George A. Weber		705 S. Ann St. #21231	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		70 00566		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00566	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Bessie Bailey</i>				1-14-70 9:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Melchon Nursing Home 4-8-70</i> <i>2337 North Charles St</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>2102</i>			
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-12-1888</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO CITY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>UNKNOWN William Longley</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN Mary?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT (Name) ADDRESS <i>Mrs. Benjamin N. Neter - 667 Riverside Dr.</i>	
18. <i>436.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Vascular Accident</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>Several years</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>1968</i> 19 <i>Jan</i> 19 <i>69</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>Jan 14</i> 19 <i>69</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Loy M. Zimmerman MD</i>				23B. DATE SIGNED <i>1/15/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/19/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Trinity Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Fisher MD</i>		25C. FUNERAL DIRECTOR <i>John J. Shavansky Inc.</i>	
26A. ADDRESS <i>901 St. Hollins</i>				26B. ADDRESS <i>23 Ind.</i>			

Letter from Dr. Zimmerman  
4-8-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-650		70 00567		BALTIMORE CITY HEALTH DEPARTMENT		70 00567	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
CRANE, ADELE L				JANUARY 15, 1970 1:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL				MARYLAND		BALTIMORE	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
None Operator		Phone Co.		02/25/16		53	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MARYLAND				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN BLUDIS				ANNA (NEE STANN) BLUDIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE				217-09-4432		ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1-8-70		Cancer		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 27 1969 to JANUARY 15 1970 that (I) (we) last saw the deceased alive on JANUARY 15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
B. Mangelberg				1-15-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
B. Mangelberg				BALTIMORE, MD 21229			
				ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/19/1970		Holy Redeemer		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 19 1970		Robert E. Talley, M.D.		John J. Moran & Son		401 E. St.	

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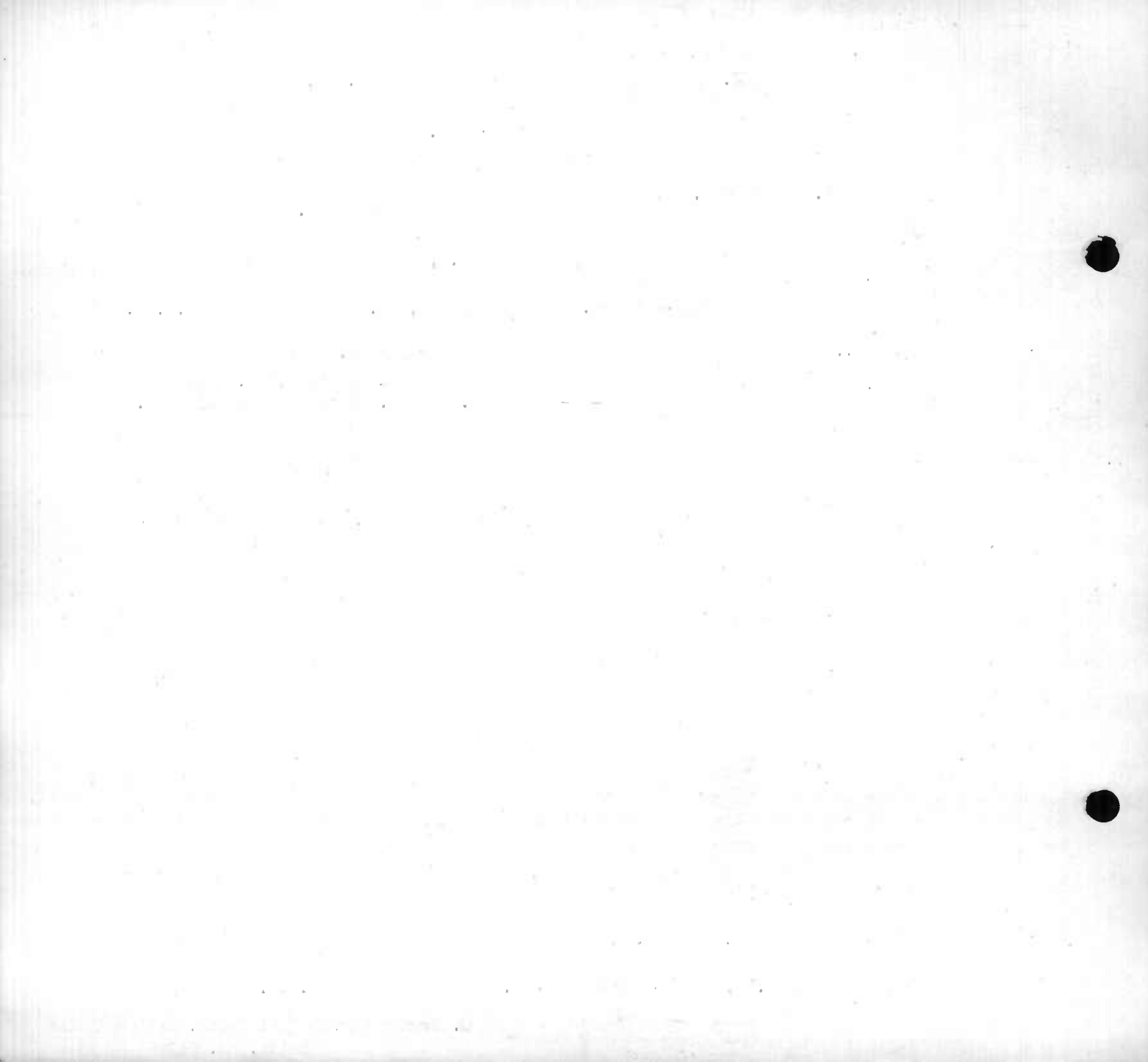
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

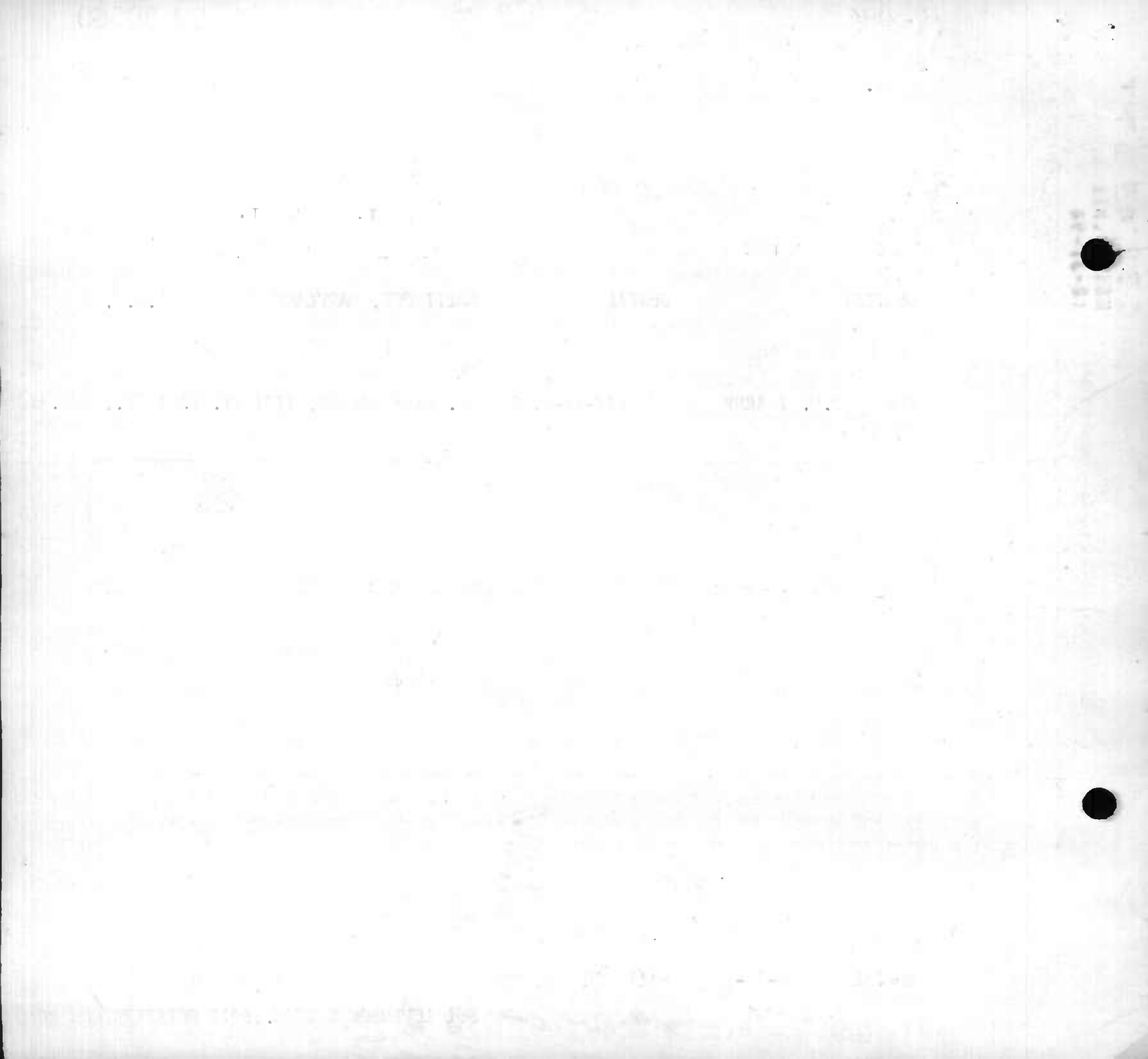
M-600 BIRTH NO. 70 00568				BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00568	
1. NAME OF DECEASED (Type or Print) <b>Pearl J. Meara</b>				2. DATE AND HOUR OF DEATH <b>Jan. 16, 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>40 St. Agnes Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Catonsville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>653 Coleraine Rd.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1889</b>		9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Coca-Cola Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Atlanta, Ga.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Samuel J. Johnston</b>				14. MOTHER'S MAIDEN NAME <b>Martha A. Walker</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>252-09-5115</b>		17. INFORMANT <b>Catonsville, Md. 21228</b> <b>Mr. John M. Meara 653 Coleraine Rd.</b>		ADDRESS	
18. <b>441.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>RUPTURED AORTIC ANEURYSM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE ARTERIOSCLEROSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 15 1969</b> to <b>JAN. 15 1970</b> , that (I) (we) last saw the deceased alive on <b>DEC. 16 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. Menendez</b>				23B. DATE SIGNED <b>1-17-70</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Marcio M. Menendez, M.D.</b>				23D. ADDRESS <b>5820 York Road Baltimore Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 19, 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		ADDRESS <b>5151 Balto. National Pike Balto. Md. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00569	
B-246 70 00569		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DR. MAX K. BAKLOR		2. DATE AND HOUR OF DEATH Jan 13, 1970 3:50 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1101			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1101 ST. PAUL ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-94	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10B. KIND OF BUSINESS OR INDUSTRY DENTAL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LOUIS BAKLOR		14. MOTHER'S MAIDEN NAME FANNIE KENTZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY		16. SOCIAL SECURITY NO. 217-38-0802		17. INFORMANT MRS. ELSA BAKLOR, 1101 ST. PAUL ST., APT. 1705	
18. 1959 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma. (B) DUE TO, OR AS A CONSEQUENCE OF: Unknown primary source (C) (biopsy proven in the chest wall)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 13, 1969 to Jan 13, 1970, that (I) (we) last saw the deceased alive on Jan 13, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C Delgado		23B. DATE SIGNED 1/13/70			
23C. PHYSICIAN'S NAME (Type) CESAR E DELGADO		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-15-70		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

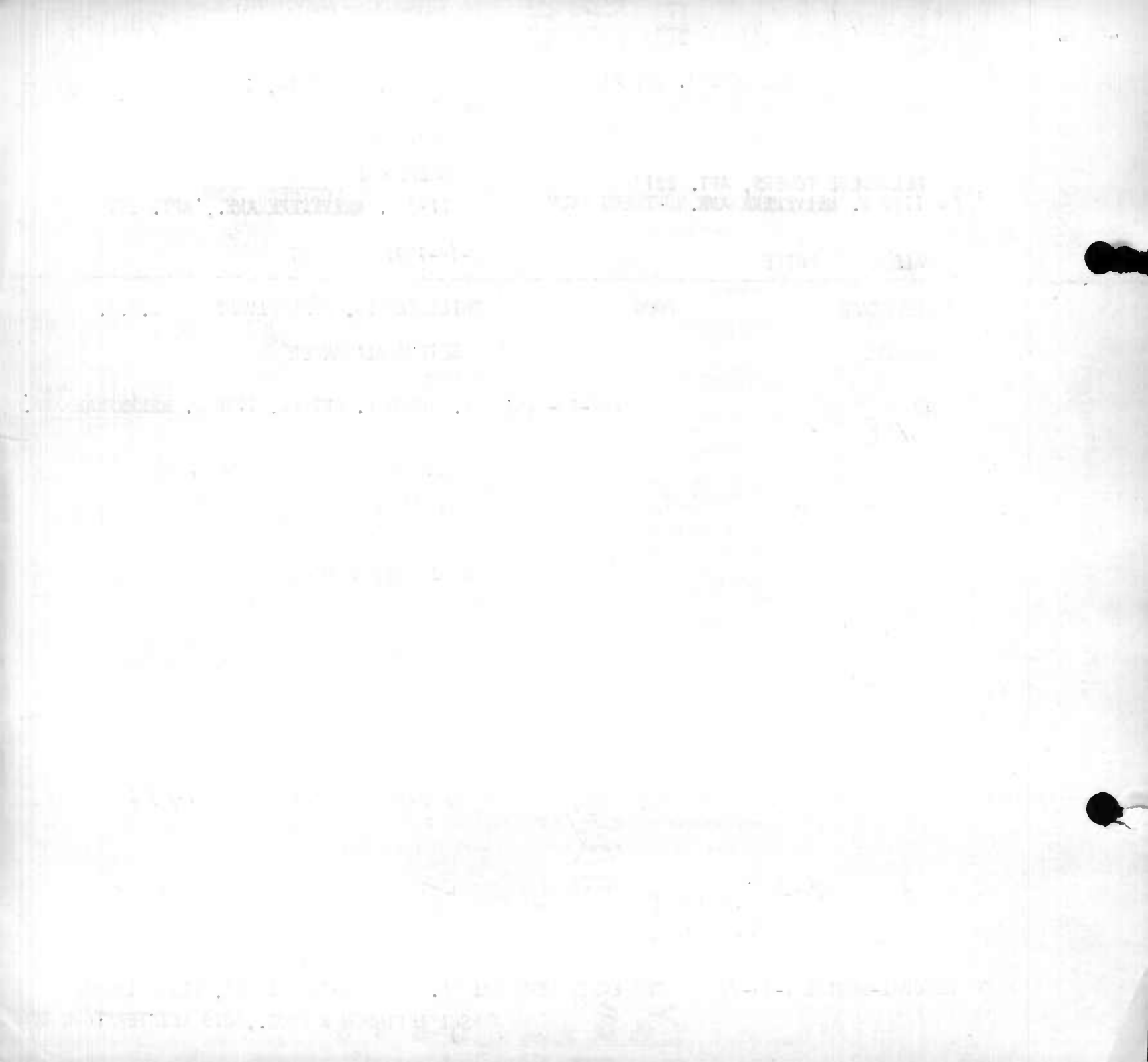




# FUNERAL DIRECTOR: IMPORTANT

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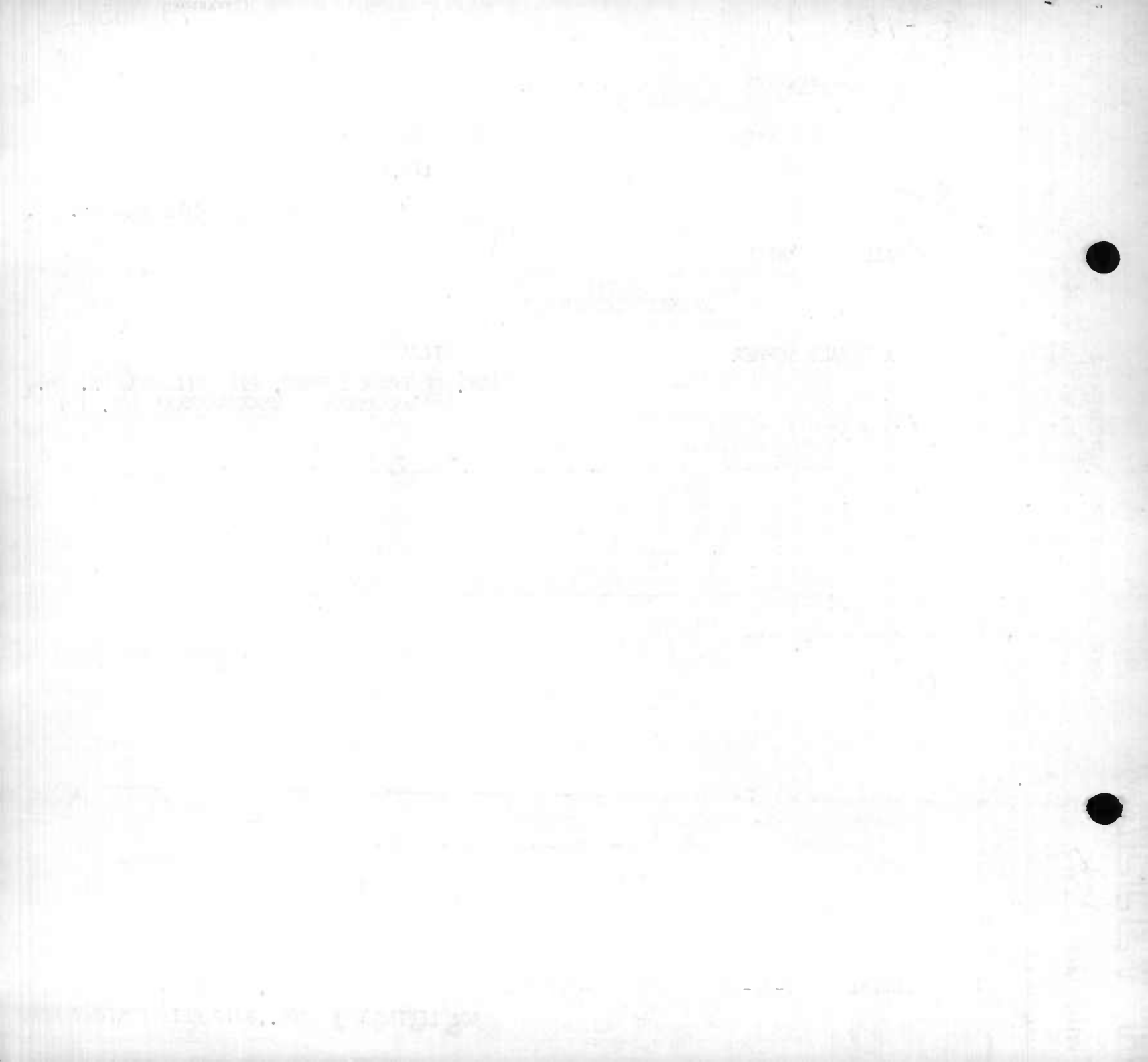
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00570	
S-340 70 00570		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THEODORE A. SEIDEL		JANUARY 14, 1970 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 BELVEDERE TOWERS, APT. 221 1190 W. BELVEDERE AVE., NORTHERN PKWY			A. STATE		B. COUNTY
			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER (NORTHERN PKWY) 1190 W. BELVEDERE AVE., APT. 221		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8-14-1902	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BROKERAGE		FOOD		PHILADELPHIA, PENNSYLVANIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNKNOWN			BERTHA ALEXANDER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		102-10-8897		MR. MYRON E. SEIDEL, 1190 W. BELVEDERE AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Carcinoma of Prostate with generalized metastasis		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			G.I. Bleeding		
			(C) 12 years		
			1 month		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
09/67		orchidectomy		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/10 1950 to 1/14 1970, that (I) (we) last saw the deceased alive on 1/14 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
REMOVAL-BURIAL		1-18-70		ROOSEVELT MEMORIAL PK.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 19 1970		Robert A. Taylor		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

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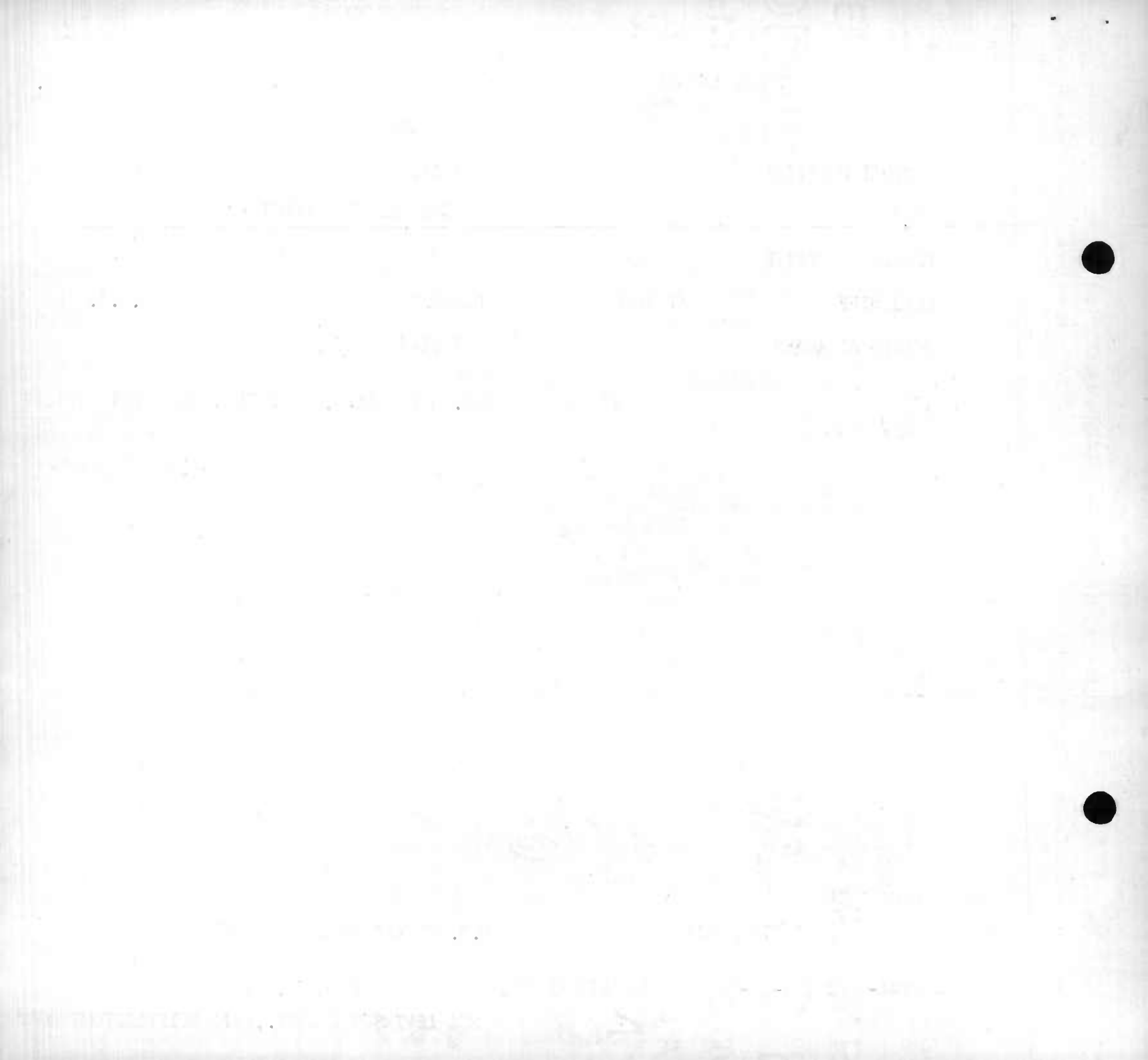
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00571</span>	
S-160 70 00571		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <del>XXXXXXXXXX</del> Bernard Sopher		2. DATE AND HOUR OF DEATH DOA Pronounced at 1/15/70 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <del>XXXXXX</del> Md. B. COUNTY Baltimore CO. 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 28 University		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 22 S. Greene Bkto		C. CITY OR TOWN BALTO, R	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 6954 XXXXXXXXXXXXX MILBROOK PK. DR.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1911	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clinical Worker		10B. KIND OF BUSINESS OR INDUSTRY OFFICE		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISRAEL SOPHER		14. MOTHER'S MAIDEN NAME HILDA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. GERTRUDE SOPHER, 6954 MILBROOK PK. DR., APT. T 1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DOA University Emergency Room (B) Cardiac Pacemaker Activity without DUE TO, OR AS A CONSEQUENCE OF: (C) Cardiac Activity - Presumed Cardiac Arrest 2° Rheumatic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/15 19 70 to 1/15 19 70, that (I) <del>was</del> lost saw the deceased alive on NEVER 19 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <i>Ernest S. Sears</i> MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Ernest S. Sears MD	
23D. ADDRESS 22 S. Greene St Bkto					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-16-70		24C. NAME of CEMETERY or CREMATORY MOSES MONTIFIORO	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR J. E. Taylor MD		25C. FUNERAL DIRECTOR SOB LEBINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00572	
K-620 70 00572		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GERTRUDE KROUSE		2. DATE AND HOUR OF DEATH JANUARY 16, 1970 7 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co. 5300			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6503 GLENWICK COURT #9			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH ABRAHAMS		14. MOTHER'S MAIDEN NAME THELMA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. RUTH MILLS, 6503 GLENWICK COURT #21209	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION TERMINAL		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		6 MONTHS	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Dec 1, 1969 to 12/10, 1969, that (I) (we) lost the deceased alive on 12/10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Irving Wolf, M.D.		23B. DATE SIGNED 1/16/70		23C. PHYSICIAN'S NAME (Type) IRVING WOLF, M.D.	
23D. ADDRESS U.S. PUBLIC HEALTH HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 1-20-70	
24C. NAME OF CEMETERY or CREMATORY WALDHEIM CEMETERY		24D. LOCATION (City, town, or county) (State) CHICAGO, ILLINOIS		24E. DATE RECD BY HEALTH DEPT. JAN 19 1970	
24F. NAME OF REGISTRAR Sol Levinson		24G. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		24H. ADDRESS	



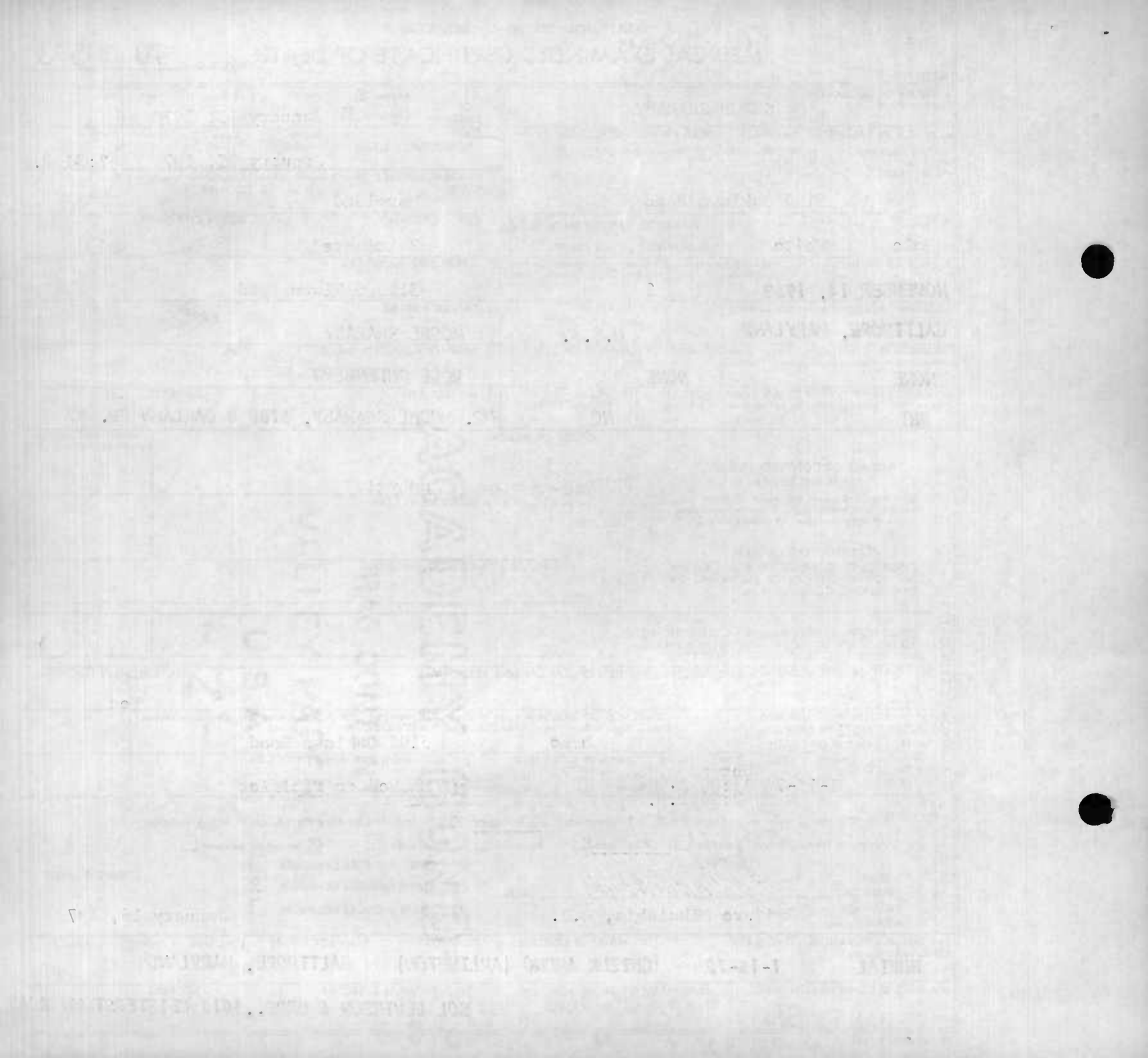
1

8-610 70 00573 BALTIMORE CITY HEALTH DEPARTMENT

64-21197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 00573

1. NAME OF DECEASED (Type or Print) SHAWN SHARABY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 15, 1970		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5100 Oaklawn Road		3. DATE PRONOUNCED DEAD January 15, 1970		2:31 P.M.
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH NOVEMBER 14, 1969		10. AGE (In years lost birthday) 2		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MOSHE SHARABY		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
15. MOTHER'S MAIDEN NAME ROSE GUTENBERG		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NO
18. INFORMANT MR. MOSHE SHARABY, 5100 B OAKLAWN RD. #7		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5100 Oaklawn Road 2833
22D. TIME OF INJURY (APPROX.) 1-15-70 11:00 A.M. to 2:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Choked on Pacifier
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 16, 1970
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-16-70		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR J.E. Seiber, M.D.
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS		

VS 151-REV. 7/1/68





70 00574

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Vallie Hayes

Vallie L. Hayes

2. DATE AND HOUR OF DEATH

Jan 16, 1970 2 05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY  
Maryland Baltimore Co

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

26 Maryland Avenue 21222

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9-15-92

9. AGE (In years  
last birthday)

77

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Matron

10B. KIND OF BUSINESS OR INDUSTRY

Dundalk Police Station

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

??

14. MOTHER'S MAIDEN NAME

??

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-10-6451

17. INFORMANT

BCH RECORDS- 4940 Eastern Avenue ADDRESS

Baltimore, Maryland 21224

18. E8801X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any,  
rise to the above cause (A) stating  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE Sepsis  
DUE TO, OR AS A CONSEQUENCE OF:(B) PARA plegia  
DUE TO, OR AS A CONSEQUENCE OF:

(C) FRACTURE CERVICAL VERTEBRAE C4-C5

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 mos

7 months

7 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1

ATHEROSCLEROTIC VASCULAR DISEASE SPINAL CORD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

26 Maryland Ave., Baltimore, Md.

21D. TIME  
OF INJURY  
(APPROX.)

May 3 1969

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☒

21F. HOW DID INJURY OCCUR?

Fell down steps of home.

22. I certify that (1) (this hospital) attended the deceased from Jan 10 to Jan 16 1970  
that (1) (we) last saw the deceased alive on Jan 15 1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wale N. Schumacher M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1-16-70

23C. PHYSICIAN'S  
NAME (Type)

Wale N. Schumacher, M.D.

23D. ADDRESS

BCH  
4940 Eastern Avenue  
Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/19/70

24C. NAME of CEMETERY or CREMATORY

Mount Olivet

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John J. Duda

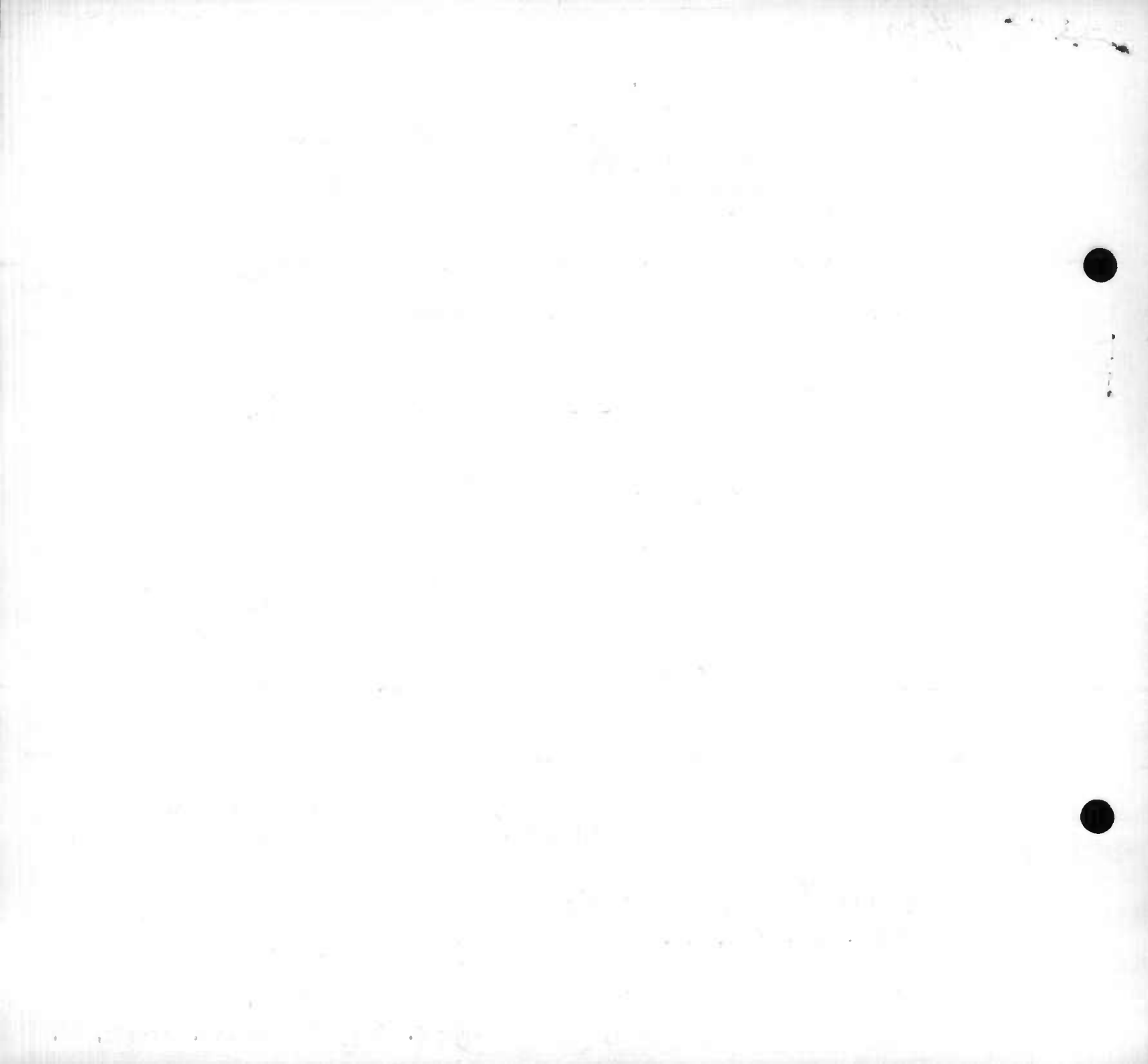
ADDRESS

7922 Wise Ave. Dundalk, Md.

21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>0-416</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00575</u>	
1. NAME OF DECEASED (Type or Print) <u>Lawrence Ray Oliver</u> <u>LAWRENCE RAY OLIVER</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 15, 1970</u>   <u>11:05 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>867 Loalan Avenue</u> <u>21222</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-22</u>	9. AGE (in years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tin Mill</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Lawrence Oliver</u>		
14. MOTHER'S MAIDEN NAME <u>Marie Cornell</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		
16. SOCIAL SECURITY NO. <u>215-18-2629</u>			17. INFORMANT <u>BCH: Records Baltimore, Maryland</u> ADDRESS <u>4940 Eastern Avenue</u> <u>21224</u>		
18. <u>250.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u> <u>50 min.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MYOCARDIAL INFARCTION</u> <u>12 HR.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DIABETES MELLITUS</u> <u>YEARS</u>		
19A. DATE OF OPERATION <u>21</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		
20A. AUTOPSY? (Yes or No) <u>YES</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (1) (this hospital) attended the deceased from <u>JANUARY 15, 1970</u> to <u>JANUARY 15, 1970</u> that (1) (we) last saw the deceased alive on <u>JANUARY 15, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael M. McConnell, M.D.</u>			23B. DATE SIGNED <u>JANUARY 15, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL M. McCONNELL M.D.</u>			23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>21224</u> <u>4940 Eastern Avenue Baltimore, Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			
24F. NAME of REGISTRAR <u>Robert E. J. J.</u>		24G. FUNERAL DIRECTOR <u>John J. Duda</u>		24H. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00576</u>
BIRTH NO. <u>D-160</u>		70 00576		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Mabel Elizabeth Devore</u>		2. DATE AND HOUR OF DEATH <u>Jan. 14, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Convalesarium</u> <u>6116 Belair Road</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Edgemere</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>3015 Delmar Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1887</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Fred Krauk</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fizzell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26-6918-A</u>		17. INFORMANT <u>Daughter:</u> <u>Mrs. Menta Strasbaugh</u> ADDRESS <u>3015 Delmar Avenue Balto. Md. 21219</u>
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arterio sclerotic heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>15 years</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Institutionally medical examined <input type="checkbox"/> <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1-6-1965</u> to <u>1-15-1970</u> that (I) (we) last saw the deceased alive on <u>Dec 19 69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Wyman K. Wong, M.D.</u>		23B. DATE SIGNED <u>1/16/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Wyman K. Wong, M.D.</u>
23D. ADDRESS <u>40 South Dundalk Avenue Dundalk, Maryland 21222</u>		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/17/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>



M-625 70 00577

## CERTIFICATE OF DEATH

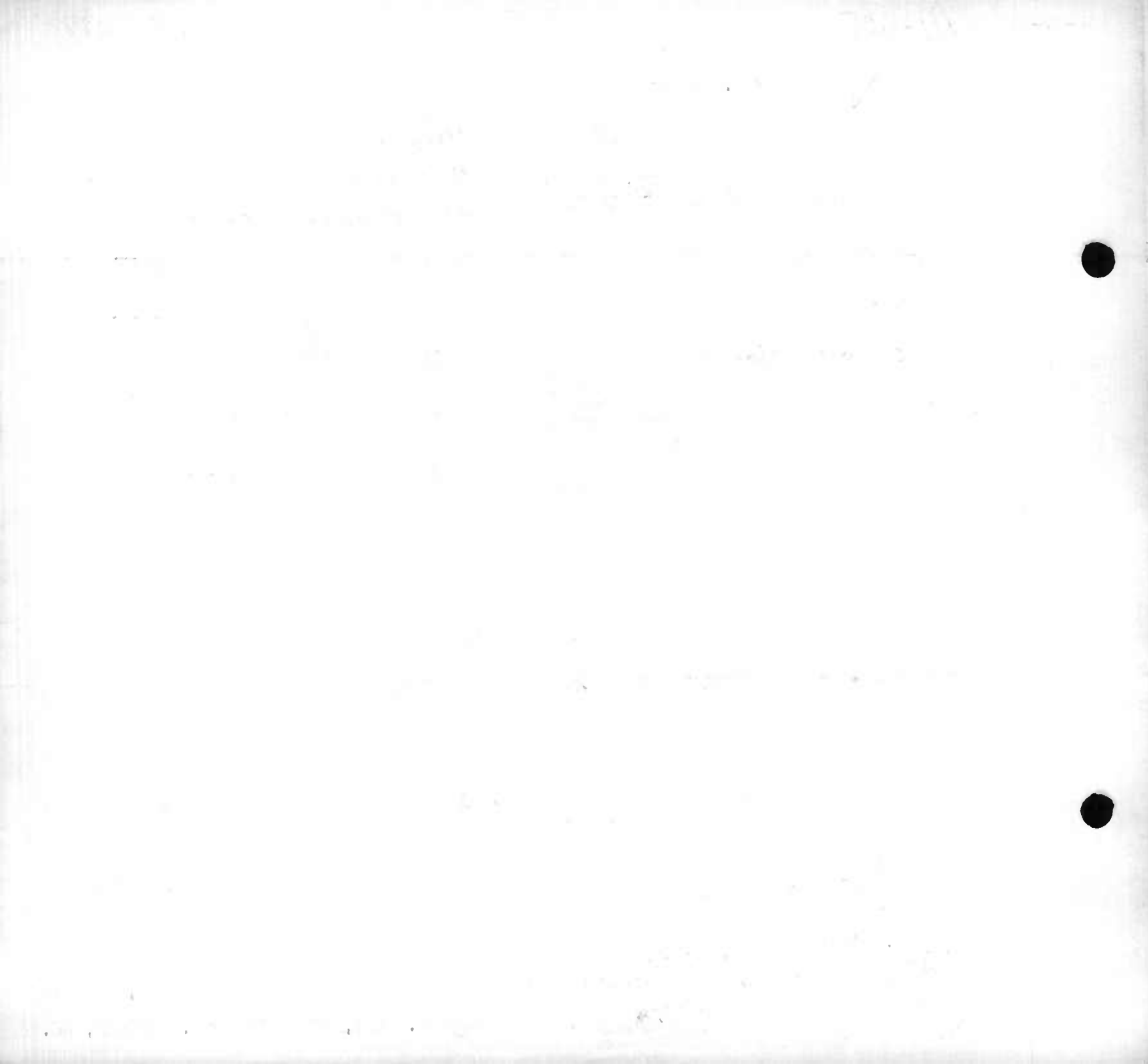
REG. NO.

70 00577 4

BIRTH NO. <u>70-01108</u>		1. NAME OF DECEASED (Type or Print) <u>Mark M. Morgan</u>		2. DATE AND HOUR OF DEATH <u>1-14-70</u> <u>1:15</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4940 Eastern Avenue Baltimore, Maryland</u> <u>Baltimore City Hosp 21224</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>423 Ostwood Road</u>		21222			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-70</u>	9. AGE (in years last birthday) <u>14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Elliott Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Betty Morgan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>4940 Eastern Avenue</u> BCH: Records Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>569.4-1-009.2</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Acute Necrotizing Enteritis</u>			
19A. DATE OF OPERATION <u>1-12-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Perforated bowel</u>		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-2-70</u> 19 <u>70</u> to <u>1-14</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-14</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Miyazono</u>				23B. DATE SIGNED <u>1-15-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. Miyazono</u>				23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/16/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			
25B. NAME OF REGISTRAR <u>John B. Duda</u>		25C. FUNERAL DIRECTOR <u>7922 Wise Ave. Dundalk, Md.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

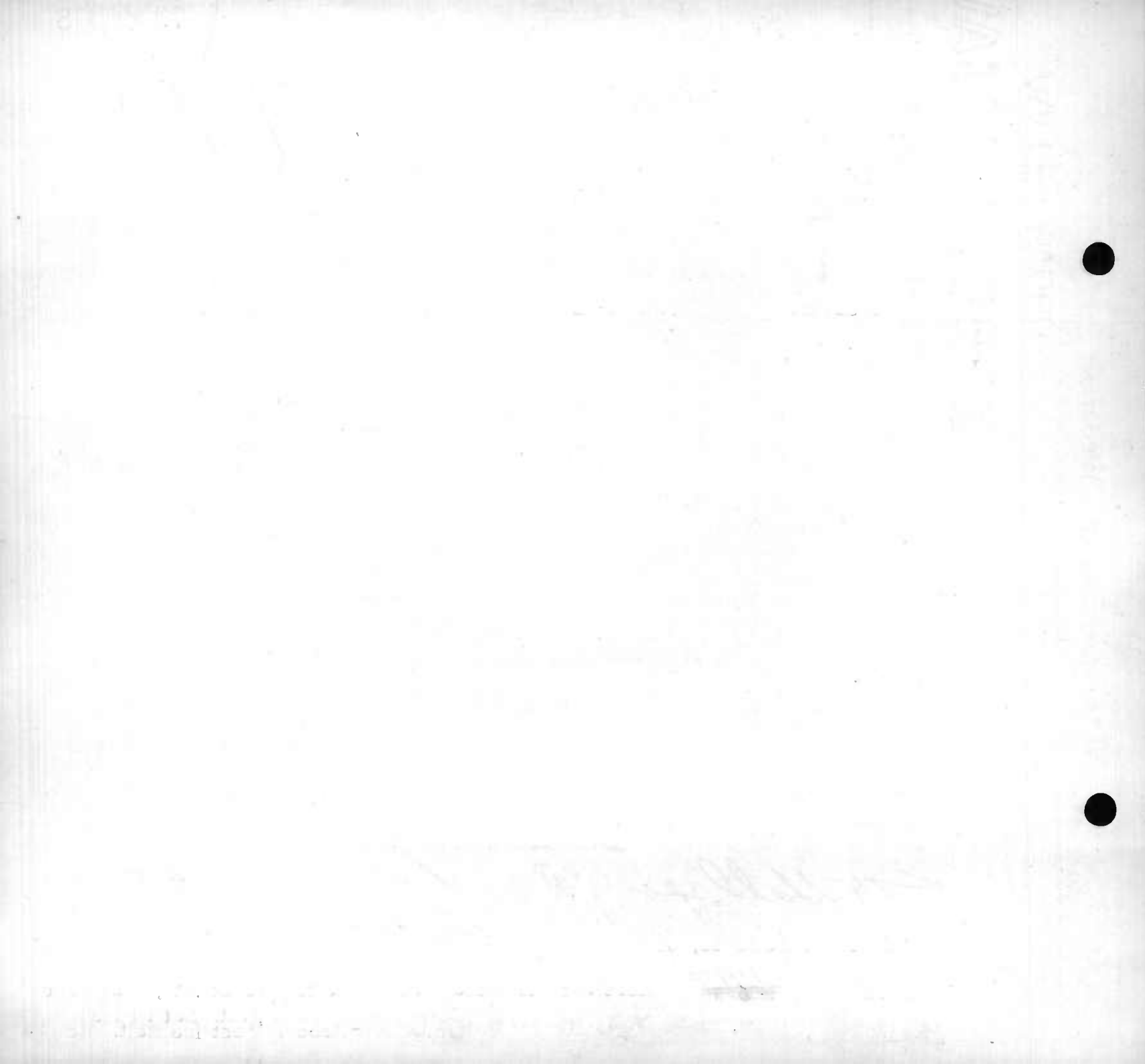




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00578	
F-236 70 00578				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY ELLEN FASSDORF</b>		2. DATE AND HOUR OF DEATH <b>1-14-70 1:30 P.M.</b>	
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UPLANDS Home For Church Women</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4501 Old Frederick Rd Baltimore Md.</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		8. DATE OF BIRTH <b>6/13/1886</b> 9. AGE (In years lost birthday) <b>83</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>HARRY ELLSWORTH WARD</b>		14. MOTHER'S MAIDEN NAME <b>EMMA VIRGINIA BEARD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-09-8144</b>		17. INFORMANT ADDRESS <b>Isabelle P. LANGLEY</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>generalized arteriosclerosis and stroke</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>generalized arteriosclerosis and stroke</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 1 year</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>none</b>					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>31 March 1966</b> to <b>Jan 14 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Jan 14 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Wm. K. Galleger, Jr.</b>				23B. DATE SIGNED <b>14 Jan 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wilmer K. Galleger, Jr.</b>				23D. ADDRESS <b>6630 BALTIMORE NATIONAL PIKE BALTO 21228</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION <b>Baltimore County, Maryland</b>		24E. DATE REC'D. BY HEALTH DEPT. <b>JAN 16 1970</b>			
25A. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25B. NAME OF REGISTRAR <b>0 0 0</b>		25C. FUNERAL DIRECTOR <b>Wm. S. Cook - Brooks West Inc. Balt. Md. 28</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

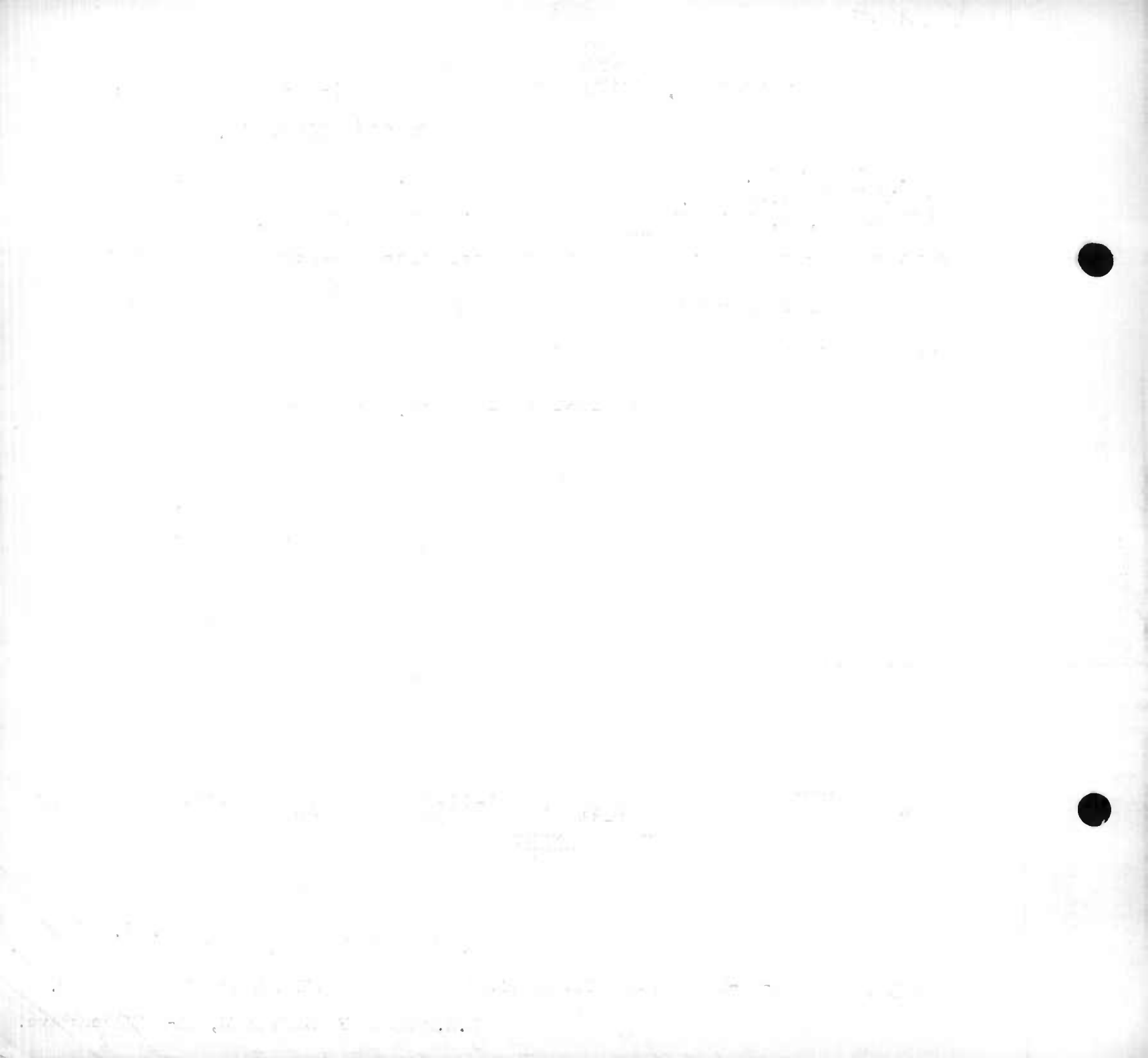
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00579</u>	
C-656				70 00579	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CROMER, JOSEPH PAUL Sr.			JANUARY 15, 1970 4:45PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
40 ST AGNES HOSPITAL			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1608 WEST PRATT STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 14 95	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RETIRED CARPENTER			VIRGINIA		U S A
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN CROMER			LELIA WINE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			224 16 6152		ST AGNES HOSP. RECORDS-BALTO MD 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cor. Pulmonale.		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Possible Anterosecilirosis.		
			(B) Bronchial Pneumonia.		
			DUE TO, OR AS A CONSEQUENCE OF:		
			Pulmonary Edema		
			(C) Bilateral Pleural Effusions.		
II			Acute Pulm. Hemorrhage.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from JANUARY 8 1970 to JANUARY 15 1970 that (I) (we) last saw the deceased alive on JANUARY 15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
ALEJANDRO MEJIA					01 15 70
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
ALEJANDRO MEJIA					St Agnes Hospital, Catonsville
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	11-19-70	Meadowridge Mem Ph Cem	Ethridge Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JAN 19 1970	Thomas J. Kenny	Thomas J. Kenny, Inc 1600 Hollist St			

to you

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-4235		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00580	
BIRTH NO. 70 00580		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FAULKNER, THELMA B		2. DATE AND HOUR OF DEATH 01-14-70 3:05P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO. 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSP. WILKENS & CATON AVE. BALTIMORE, MD. 21228C		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1102 ELMRIDGE AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-16-03	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ROBERT SYLVIA		DEC 'D		14. MOTHER'S MAIDEN NAME NORA CONNOR DEC 'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-2754-A		17. INFORMANT ST. AGNES RECORD ROOM WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac shock (B) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1-10-70 to 1-14-70 that (X) (we) last saw the deceased alive on 1-14-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ching-Hui Tsai, M.D.		23B. DATE SIGNED 1-14-70		23C. PHYSICIAN'S NAME (Type) CHING-HUI TSAI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-17-70		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE COUNTY		24E. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.		24F. LOCATION (City, town, or county) BALTO. MD. 21229	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR H. H. HUBBARD FUNERAL HOME, 41-5 Wilkens Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 70 00581				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00581	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WHEAT, HILDA C</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 13, 1970 2:45P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2854</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>470 ST. AGNES HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4706 AMBERLY AVE 21229</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01/31/97</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Rickell</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Lambert</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Carroll O. Wheat, 4706 Amberly Ave. ST. AGNES HOSPITAL RECORDS</b>			
18. <b>03801</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>pneumonia</b>  (B) <b>questionable Staph infection</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Septicemia</b>  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 6 1970</b> to <b>JANUARY 13 1970</b> that (I) (we) last saw the deceased alive on <b>JANUARY 13 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1/13/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>AF2AL</b>		23D. ADDRESS <b>BALTO, MD 21229 ST. AGNES HOSP; CATON &amp; WILKENS AVES</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-16-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

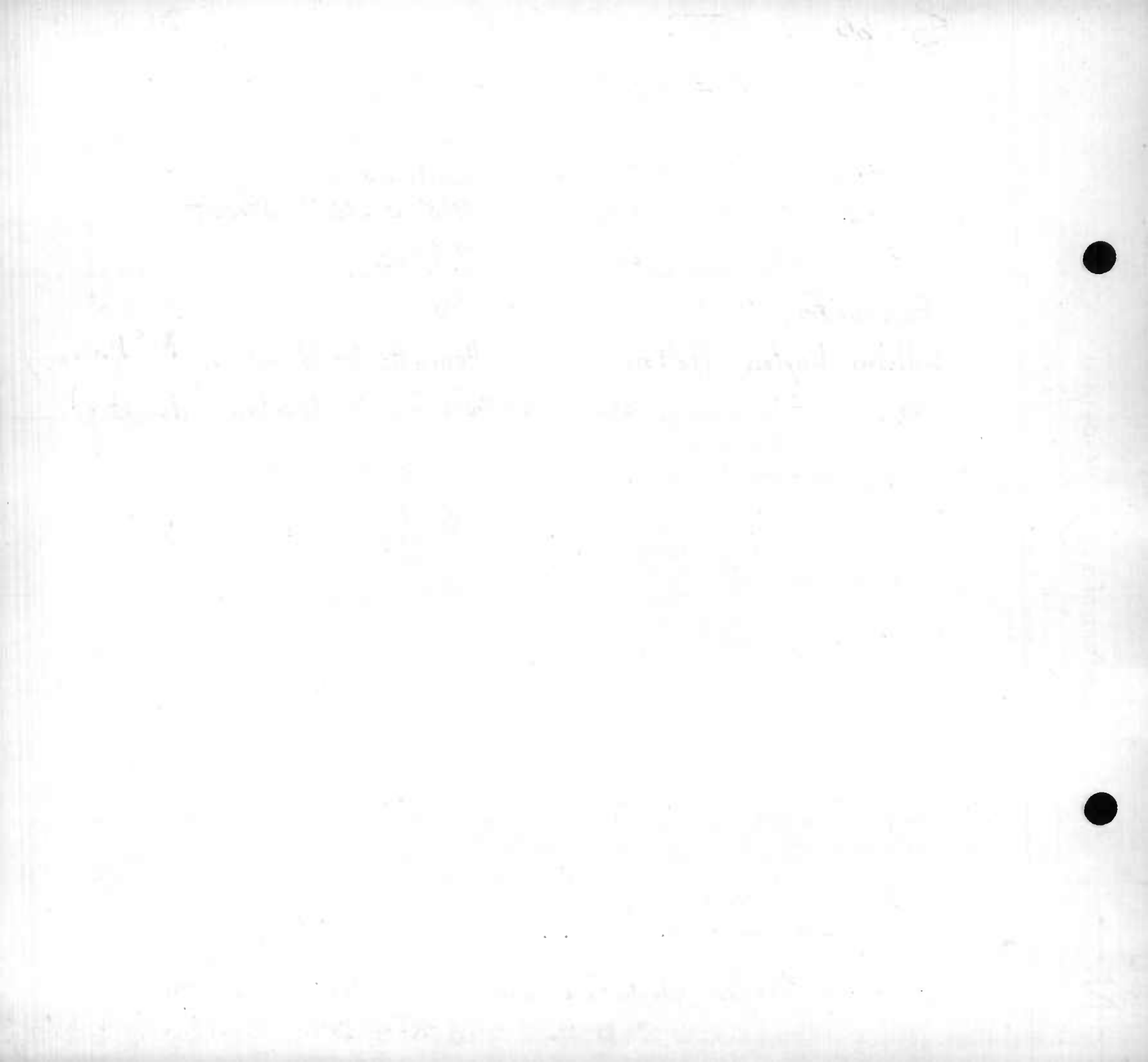
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00582	
S-660 70 00582				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Henrietta Holton Shearer</i>		2. DATE AND HOUR OF DEATH <i>1-16-70</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>House IN The Pines</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90 <i>5837 BELAIR ROAD</i>		E. STREET AND NUMBER <i>908 E 30th Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/6/92</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Layton Holton</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Goldsborough McKenney</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-307-160</i>		17. INFORMANT <i>Mr. Henry P. Barton (daughter)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>coronary occlusion</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ant. rel. cv. disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>2/12 1966</i> to <i>1/16 1970</i> , that (I) (we) last saw the deceased alive on <i>1/16 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Maurice Feldman Jr.</i>		23B. DATE SIGNED <i>1/17/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Maurice Feldman Jr.</i>	
23D. ADDRESS <i>6610 CROSS COUNTRY BLVD</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/19/70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Chesterfield Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Centreville, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>	
25B. NAME OF REGISTRAR <i>Barry E. Kelly</i>		25C. FUNERAL DIRECTOR <i>Barton Bros</i>		25D. ADDRESS <i>Centreville Md</i>	



1

0-400 70 00583 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00583

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDNA OHL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 15, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 15, 1970 1:47 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb 22, 1912		10. AGE (In years lost birthday) 57	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Margaret Tillman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		17. SOCIAL SECURITY NO. 216-28-8180	
18. INFORMANT Howard OHL		ADDRESS 1931 Ramsey St. Balto., Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED January 16, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR George L. Schwab	
25C. FUNERAL DIRECTOR		ADDRESS Balto., Md.	

VS 151-REV. 1/1/68

ACADEMY BOND

FOR RENT

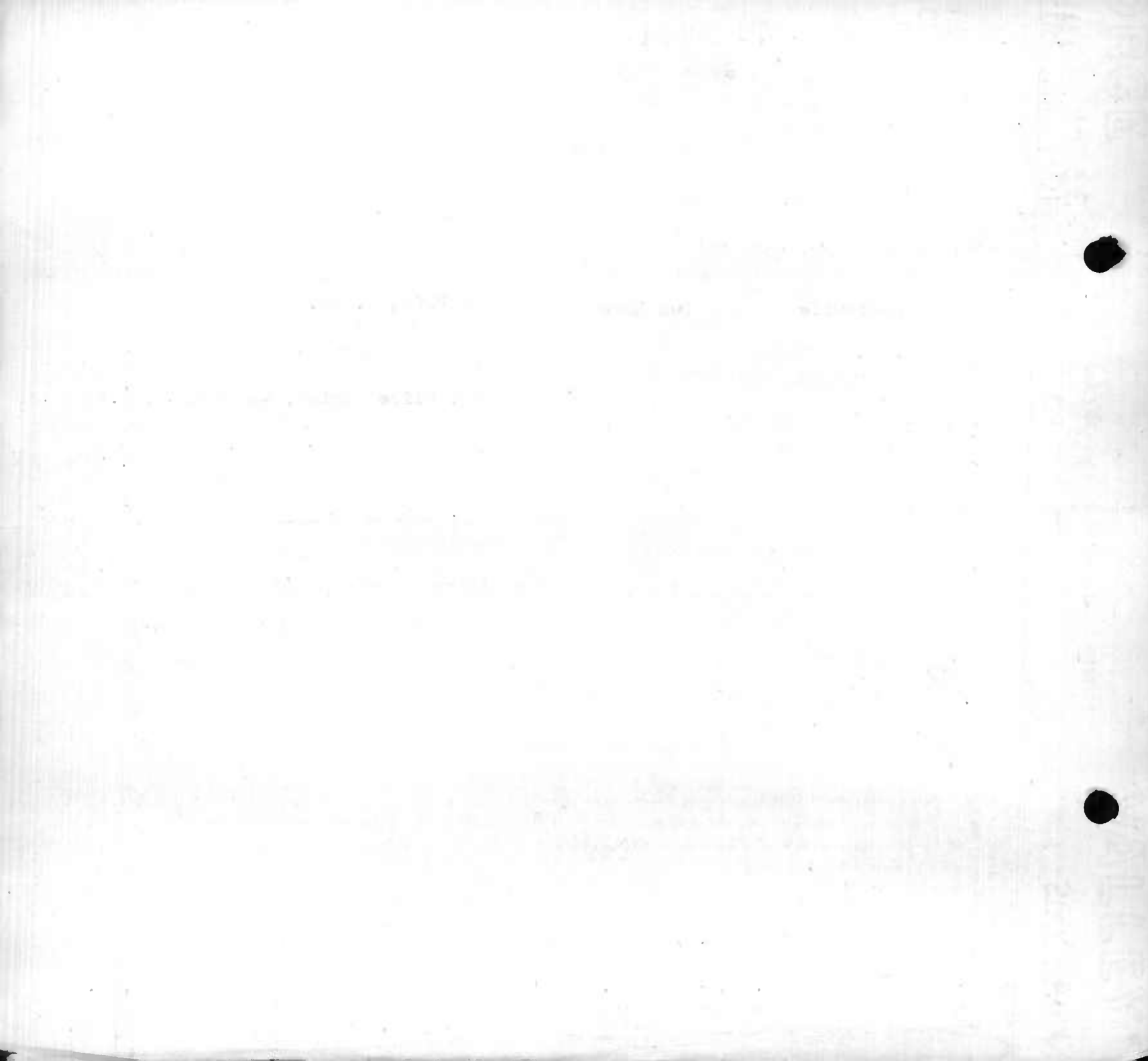
FOR RENT

FOR RENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00584	
G-263 70 00584		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GOGERTY, Twila		1/13/70 10:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
The Johns Hopkins Hospital		Maryland Allegany			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		14 Virginia Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/07/99	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		JUNIOR, W. VA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
G. W. Corrick		Mattie Row			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Mrs. Alice Zorick, Cumberland, Md. Daughter	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
394.0 I		cardiac insufficiency		1 min	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		9 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		long term	
II		(C) sepsis, R pulmonary infarct			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		1/14		rheumatic mitral	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/11 to 1/13 19 69 to 1/13 19 69, that (I) lost saw the deceased alive on 1/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
R Katz		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		1/13/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard Katz, M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Jan. 16, 1970	St. Mary's Cemetery	Cumberland, Allegany, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JAN 19 1970	Robert E. [unclear]	James F. Scarpelli, Cumberland Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00585		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 00585	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr. BRUCE MITCHELL SHU		2. DATE AND HOUR OF DEATH Jan 12 <sup>th</sup> 1970 4.50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
48 Maryland General Hospital		D. STREET ADDRESS (If rural, give location) 1632 N. Calver St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 6/29/1904	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ira D. Shu		14. MOTHER'S MAIDEN NAME Elizabeth Lazenby	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-8204		17. INFORMANT Mr. Paul Shu ADDRESS Alexandria, Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Shock & Cardiac Arrest (B) DUE TO Myocardial Infarction? (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. S. AL-IBRAHIM M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/12/1970			
23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM M.D.		23D. ADDRESS Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/70		24C. NAME of CEMETERY or CREMATORY Mt Comfort	
24D. LOCATION (City, town, or county) (State) Fairfax Co., Virginia		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970 Robert E. Taylor, M.D.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR ADDRESS Cunningham Funeral Home, Inc. Alexandria, Va.					

THE LINDSEY HOUSE

1890-1891

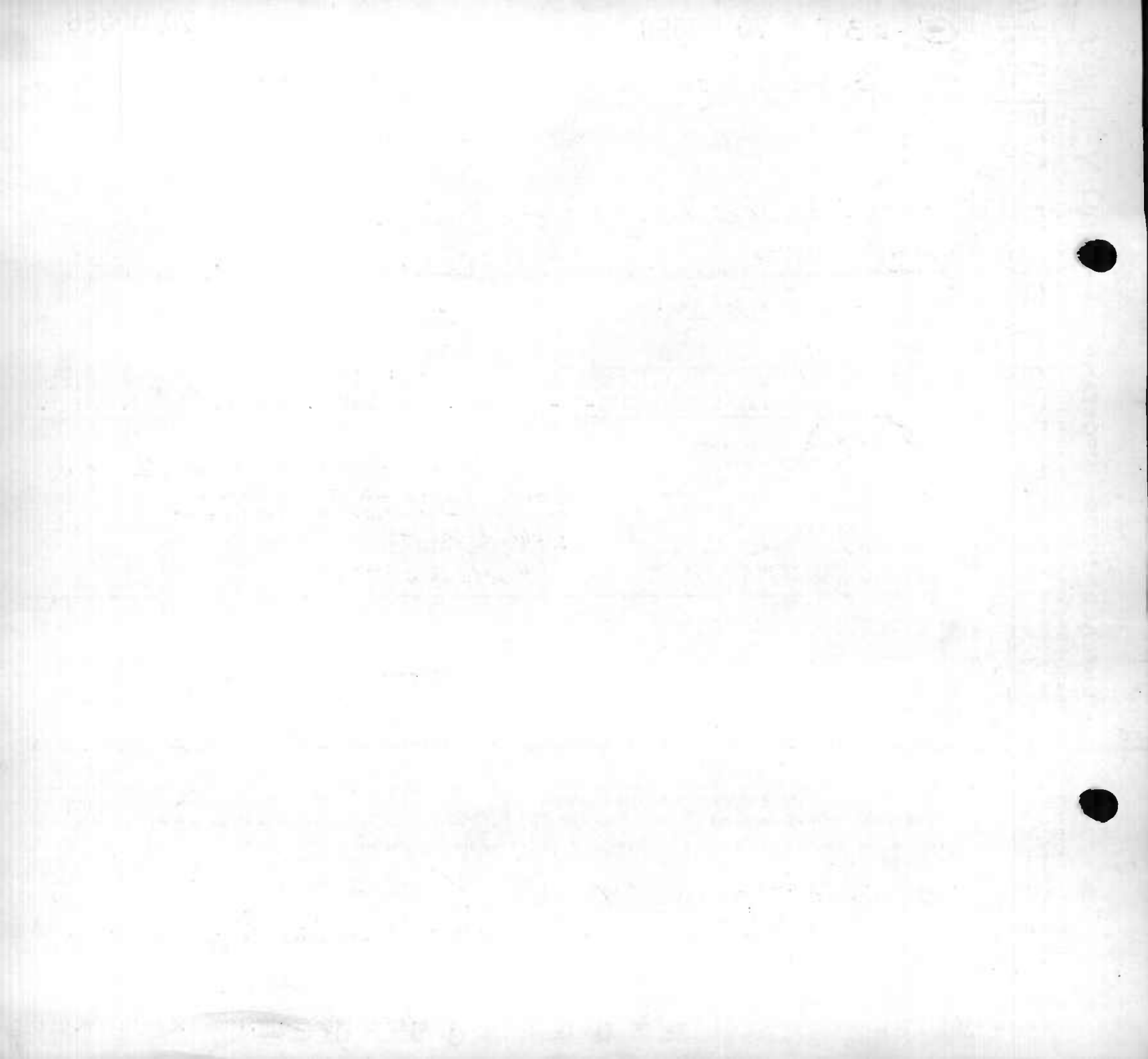
1890-1891



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635 70 00586				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00586	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <del>XXXXXXXX</del> Edward STEWART GORDON				2. DATE AND HOUR OF DEATH 1/18/70 1 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Harford Gardens Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1883	
9. AGE (In years last birthday) 86 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bookkeeper		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW XX I		16. SOCIAL SECURITY NO. 197-16-0504		17. INFORMANT : wife Mrs. Florence E. Gordon, 1913 St. Paul St.		ADDRESS 21218	
18. 5339 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Right Bronchopneumonia Left Hemiplegia - Arteriosclerosis Cerebral & general atherosclerosis PEPTIC ULCER & (Psoriasis) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. B. Levin M.D.				23B. DATE SIGNED Jan. 15, 1970		23C. PHYSICIAN'S NAME (Type) M. B. LEVIN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/70		24C. NAME OF CEMETERY or CREMATORY WOODLAWN		24D. LOCATION (City, town, or county) (State) BALTIMORE, CO. MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR STEWART & MOWEN		25C. FUNERAL DIRECTOR CO. 108 W. North Av. City		ADDRESS	



70 00587 BALTIMORE CITY HEALTH DEPARTMENT X

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00587

BIRTH NO. *No Record*

1. NAME OF DECEASED (Type or Print) <b>DIANA JEAN PARSONS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 13 70 11:15 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>City Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1970 11:15 a.m.</b>	
6. SEX <b>Female</b> 7. RACE <b>White</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto. City,</b>	
9. DATE OF BIRTH <b>Nov. 1, 1969</b> 10. AGE (In years last birthday) <b>0</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. <b>2 12 1</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		E. STREET AND NUMBER <b>81rd 423 Eastern Ave.</b>	
13. FATHER'S NAME <b>Unknown,</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None, Infant</b> 14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Jean Parsons</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No,</b>	
17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT ADDRESS <b>Mrs. Jean Parsons, 423 Eastern Ave. Balto. Md.</b>	

19. **795 X I** CAUSE OF DEATH

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

**ANTECEDENT CAUSES**  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

**II**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

(A) IMMEDIATE CAUSE **Sudden death in infancy**  
DUE TO, OR AS A CONSEQUENCE OF:

(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION <b>32</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>YES</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *[Signature]* M.D. **Isidore Mihalakis, M.D.** CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Isidore Mihalakis, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **1/13/70**

ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hillcrest Burial Park,</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Allegany Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>Md. 21502 202 Greene St. Cumberland,</b>	

ACADEMIC RECORD

3/4

Nov. 1, 1949

10000000

None, in fact

No,

None

None

10000000

None, in fact

Mr. J. J. Johnson, 422 East 10th St., St. Paul, Minn.

11/1/49

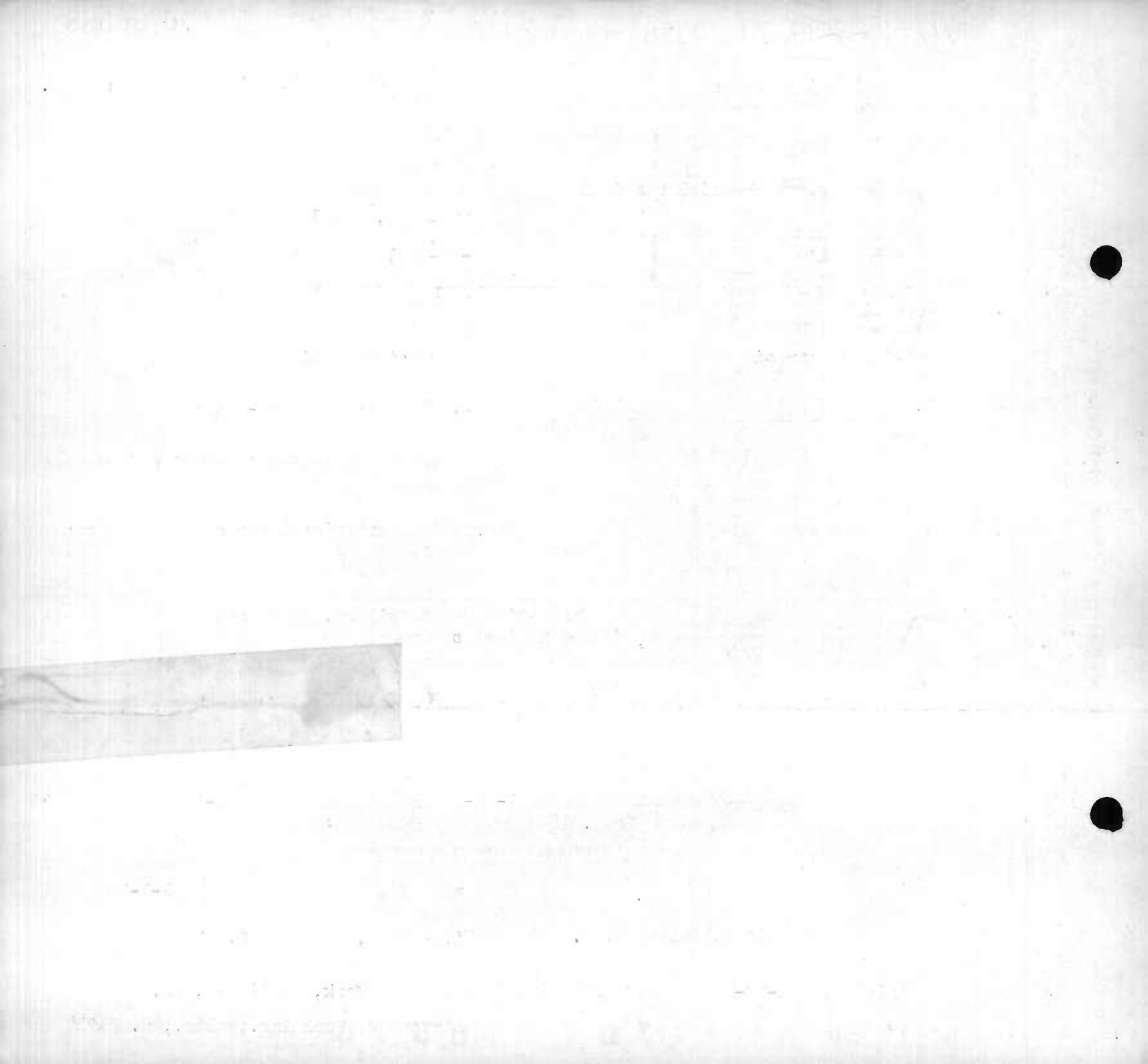
10000000

Mr. J. J. Johnson, 422 East 10th St., St. Paul, Minn.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00588	
M-522 70 00588				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Petrina Mancuso</b>				2. DATE AND HOUR OF DEATH <b>January 7, 1970 1:00 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Ford Road, 21051</b> <b>Fork, MD</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-27-1887</b>	9. AGE (In years last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Luigi Sciabarrasi</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Valanti</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216328804B</b>		17. INFORMANT <b>Mr. Nicholas Mancuso - Same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized arteriosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
II				Congestive heart failure, compensated and anginal syndrome	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from <b>7-25-68</b> <b>19 68</b> to <b>1-7</b> <b>19 70</b> , that (I) (we) last saw the deceased alive on <b>Sept. 18</b> <b>19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Phyllis K. Pullen</b>				23B. DATE SIGNED <b>1-7-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Phyllis K. Pullen M. D.</b>				23D. ADDRESS <b>Kingsville, Maryland 21087</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Fork Methodist Cemetery</b>	
24D. LOCATION <b>Fork, Baltimore, Md.</b>		24E. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto., Md. 21214</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. ADDRESS <b>0 0 0 0</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00589	
S-452 70 00589		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Beulah Virginia Slovaker</i>		2. DATE AND HOUR OF DEATH <i>Jan 15, 1970 10:10 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>1307</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>4300 Grandview Ave</i>		C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>918 W 38th ST</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 6 1886</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales lady</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DEPT STORE-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Sullivan</i>			
14. MOTHER'S MARDEN NAME <i>?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>			
16. SOCIAL SECURITY NO. <i>214-01-2906</i>		17. INFORMANT ADDRESS <i>Beulah W. Slovaker 4300 Grandview Ave</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes Mellitus</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Rectal Carcinoma</i>			
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus</i>		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>August 1969</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Colostomy</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NONE</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NONE</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 1968</i> to <i>Jan 15 1970</i> , that (I) (we) last saw the deceased alive on <i>Jan 14 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alan B Cohen MD</i>		23B. DATE SIGNED <i>Jan 15, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Alan B Cohen MD</i>	
23D. ADDRESS <i>3501 ST Paul ST - Balto Md 21218</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-19-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION <i>Balto Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>		25B. NAME OF REGISTRAR <i>Blaise J. Kelly, M.D.</i>		25C. FUNERAL DIRECTOR <i>Paul E. Gilmawath</i>	
25D. ADDRESS <i>3615 Chestnut Ave</i>					

✓  
13-175  
P18 L 2874 27  
DUC 1181

USA

Maryland

✓  
W  
Sullivan  
Sullivan

214-01-2206

Metastatic carcinoma

Rectal Carcinoma

Diabetes Mellitus

No

Excluding

March 1968

None None

Jan 12

March 30

Jan 12

✓  
Glen B. Cohen MD

3201 27 Post 27 314 Mark 2



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>P-632 70 00590</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">70 00590</span>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Frieda W. Pertsch (FRIEDA WIEGHARDT PERTSCH)</u>		2. DATE AND HOUR OF DEATH <u>1/18 1970</u> <span style="float: right;"><u>850</u> a.m.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> <u>3rd Street Balto Md</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2633</u> C. CITY OR TOWN <u>Bachman</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3103 Kentucky Avenue</u> <u>3303</u>	
5. SEX <u>female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1985 10/14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>Mr. W. Margaret Frederick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gudenus</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> If yes, give war or dates of service <u>220 44</u>		16. SOCIAL SECURITY NO. <u>3443 J 1</u>	
17. INFORMANT <u>Mrs. Milton L. Dorsch</u>		ADDRESS <u>5406 Hillburn Avenue 21214</u>	
18. <u>427.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Heart Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>12-30-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>	
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>U</u> (this hospital) attended the deceased from <u>12-30-69</u> to <u>1/18-70</u> that <u>U</u> (we) last saw the deceased alive on <u>1/18-70</u> and that <u>in</u> (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) <u>did not</u> view the body after death.			
23A. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>		23B. DATE SIGNED <u>1/18/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>D.P. VAN KAMMEN M.D.</u>		23D. ADDRESS <u>Union Mem. Hospital 3rd Street Balto</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>Henry Sander &amp; Sons Inc.</u>		ADDRESS <u>Baltimore Maryland 21213</u>	

$\frac{1}{x} = x^{-1}$

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

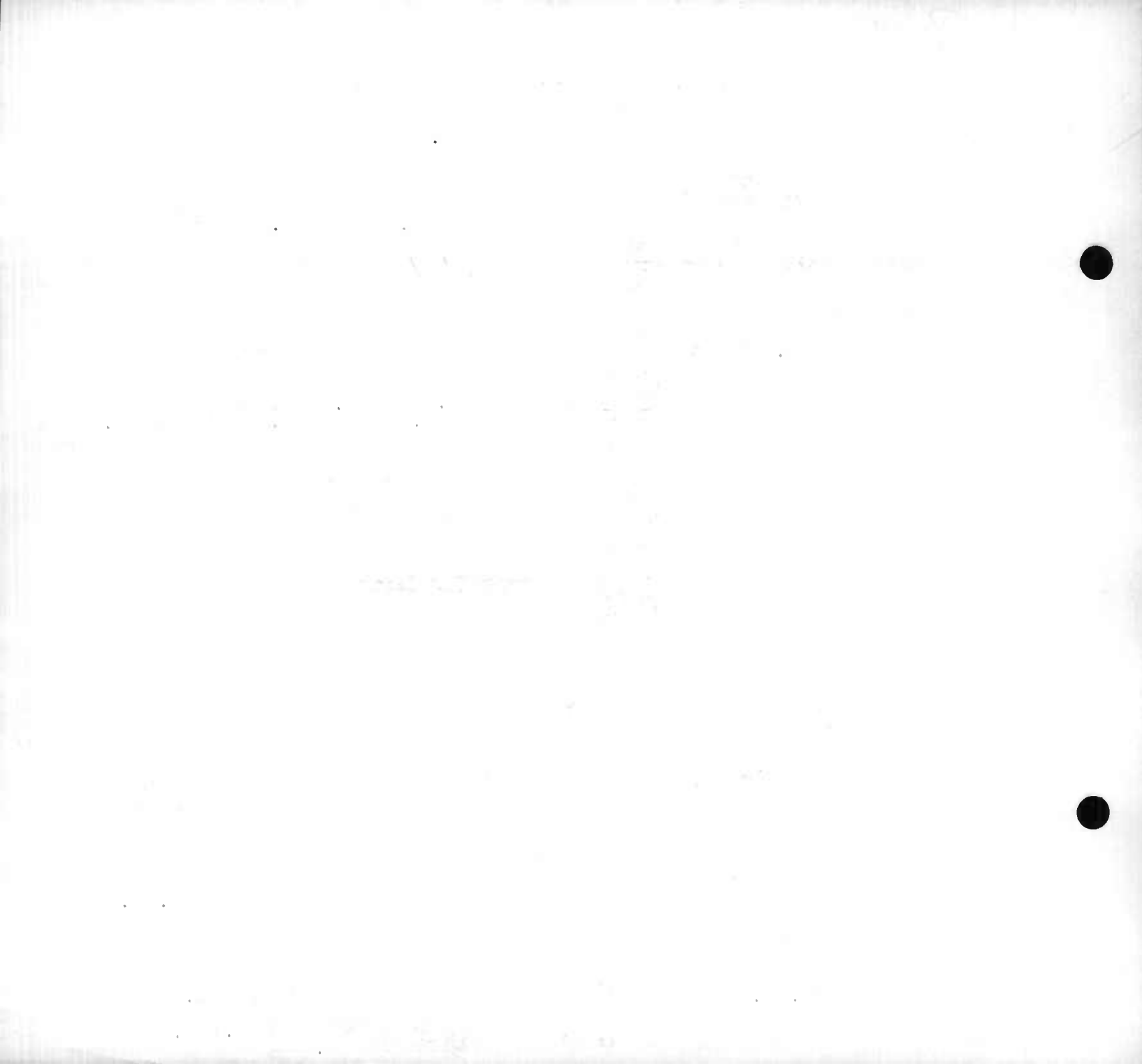
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. _____	
M-324 70 00591		70 00591	
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Raymond W. Mitchell</i>		2. DATE AND HOUR OF DEATH <i>1-15-70 11 PM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 MARYLAND GENERAL HOSPITAL</i>		A. STATE <i>Md.</i> B. COUNTY <i>902</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>1648 Shadyside Rd.</i>		E. DATE OF BIRTH <i>7-8-90</i>	
F. AGE (In years last birthday) <i>79</i>		G. AGE (In years last birthday) <i>79</i>	
H. Under 1 Yr. Months Days Hours Min.		I. Under 24 Hrs. Min.	
5. SEX <i>M</i>		6. RACE <i>W</i>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>		8. DATE OF BIRTH <i>7-8-90</i>	
9. AGE (In years last birthday) <i>79</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POLICEMAN RETIRED</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE MITCHELL</i>		14. MOTHER'S MAIDEN NAME <i>VIRGINIA CARROLL</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219 28 7330</i>	
17. INFORMANT <i>Miss Elenor K. Mitchell</i>		ADDRESS <i>1648 Shadyside Road 21217</i>	
18. <i>153.8</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Uremia secondary to destruction</i> DUE TO (B) <i>Adenocarcinoma of the colon</i> DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>13 months</i>	
19A. DATE OF OPERATION <i>Dec 14 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>adenocarcinoma colon</i>	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <i>1-2</i> 19 <i>70</i> to <i>1-15</i> 19 <i>70</i> , that <del>(H)</del> (we) last saw the deceased alive on <i>1-15</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (did not) view the body after death.			
23A. SIGNATURE <i>Michael P. Buchness</i>		23B. DATE SIGNED <i>1-15-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael P. Buchness</i>		23D. ADDRESS <i>Maryland General</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/19/70</i>	
24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Kelly, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Henry Sander &amp; Sons Inc.</i>		25D. ADDRESS <i>Baltimore Maryland 21206</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

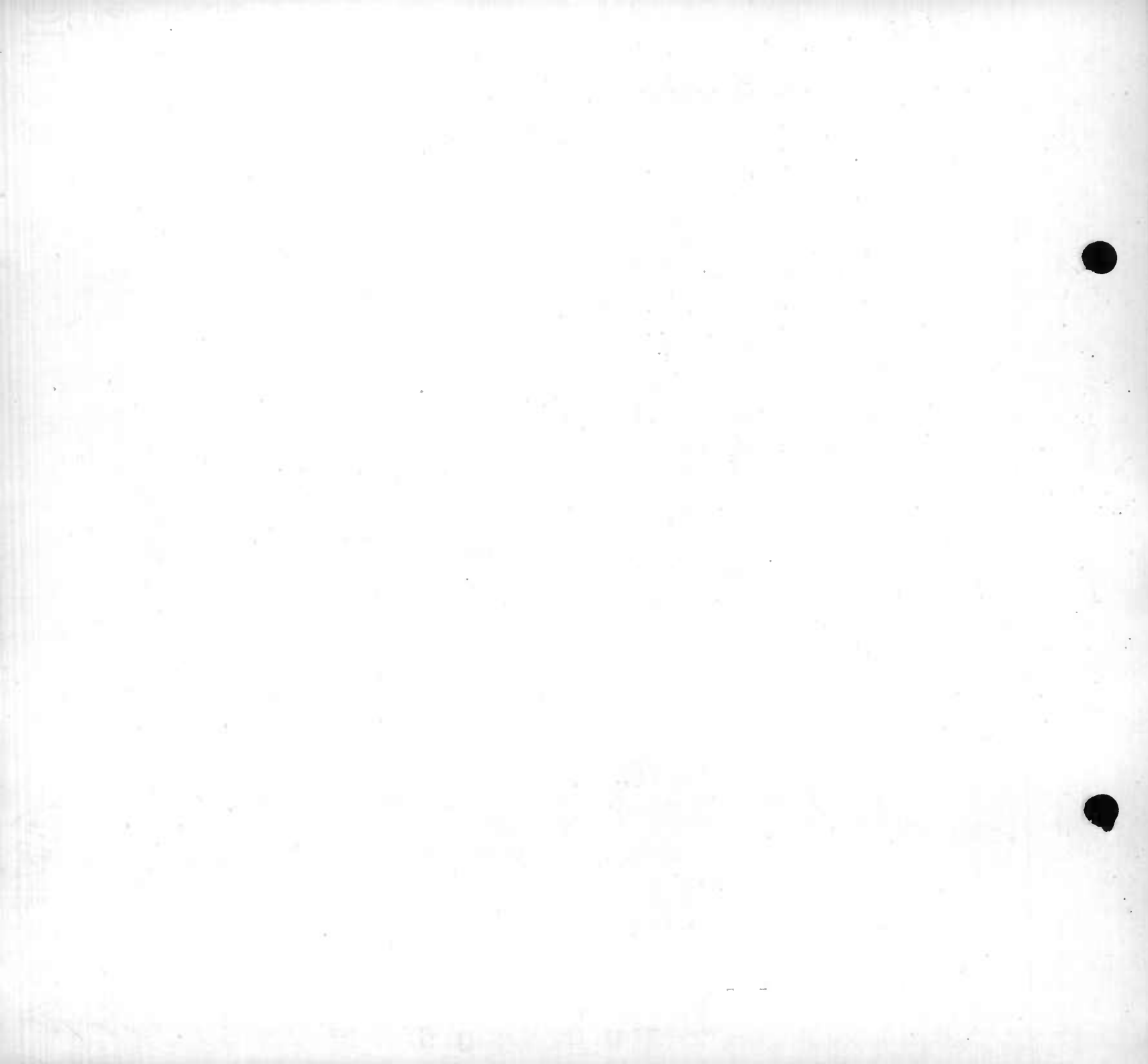
BIRTH NO. <u>R-236</u>				BALTIMORE CITY HEALTH DEPARTMENT		70 00592		CERTIFICATE OF DEATH		REG. NO. <u>70 00592</u>	
1. NAME OF DECEASED (Type or Print) <u>Nina Ricedorff (NINA RICEDORFF)</u>						2. DATE AND HOUR OF DEATH <u>1-16-1970</u> <u>8:15</u> A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>524 N. Charles St.</u> <u>21201</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/10/80</u>		9. AGE (In years last birthday) <u>89</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horace A. Gilbert</u>						14. MOTHER'S MAIDEN NAME <u>Frances Goodrich</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-14-1379</u>		17. INFORMANT ADDRESS <u>Mrs. Lorna J. Ellis (daughter)</u> <u>524 N. Charles St. Baltimore Md 21201</u>					
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary edema</u> ANTECEDENT CAUSES <u>Chronic renal failure</u> <u>ASCVD</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ASCVD</u>						CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic renal failure</u> <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic renal failure</u> <u>ASCVD</u> (C) <u>Chronic renal failure</u> <u>ASCVD</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>524 N. Charles St. Balto. 21201</u>					
21D. TIME OF INJURY (APPROX.) <u>Dec 3, 1969 ?</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell from chair to floor.</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>12-28-1969</u> to <u>1-16-1970</u> and that (I) (we) last saw the deceased alive on <u>1-16-1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>H- Makipou</u>						23B. DATE SIGNED <u>Jan. 16. 1970</u>			23C. PHYSICIAN'S NAME (Type) <u>Houshang- Makipou</u>		
23D. ADDRESS <u>Mercy Hospital</u>						23E. ADDRESS <u>Mercy Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan. 17. 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>				25B. NAME OF REGISTRAR <u>Henry Sander &amp; Sons, Inc.</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore Md.</u>			



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00593</u>	
T-300 70 00593		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Willie B. Todd</u>		2. DATE AND HOUR OF DEATH <u>1-11-70</u> <u>3 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1601</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>827 North Arlington Ave 21217</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/15</u>	9. AGE (In years lost birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Allan Todd</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-6958</u>		17. INFORMANT <u>Mr. Allen Campbell</u> ADDRESS <u>4410 Norflork Ave.</u> <u>Bolton Hill Nursing Home</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>coronary heart failure</u>  (B) <u>arteriosclerosis generalized</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>  (C) <u>diabetes mellitus</u> <u>years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/1/69</u> 19 <u>70</u> to <u>1/11/70</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>AL H. Macht MD</u>		23B. DATE SIGNED <u>1/12/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>		23D. ADDRESS <u>2. E Real St Baltimore 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-15-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. (City, town, or county) (State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>	
25D. ADDRESS <u>3035 W. North Avenue</u>					

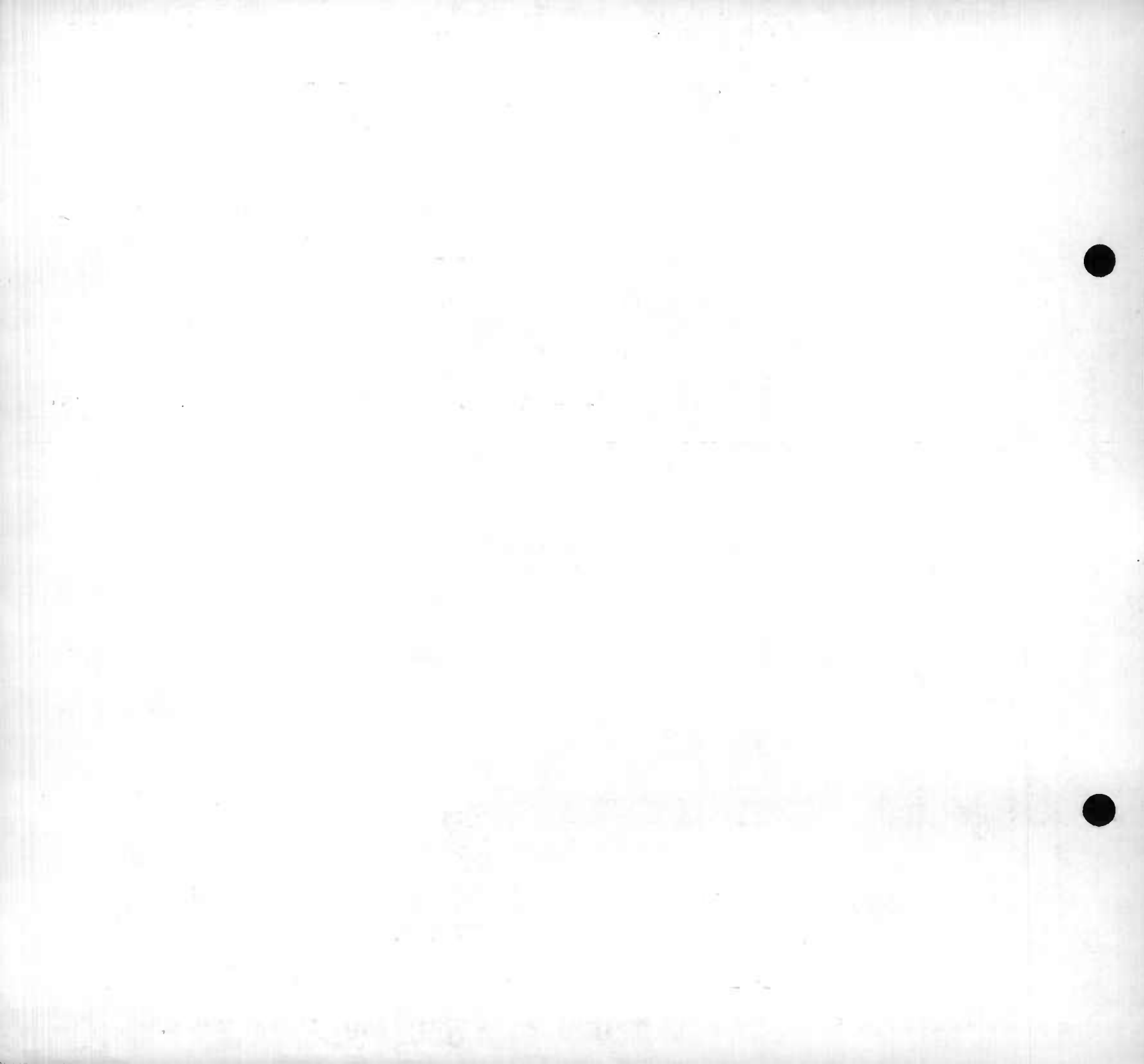




**FUNERAL DIRECTOR: IMPORTANT**

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Baltimore City Health Department				REG. NO. <span style="float: right;">70 00594</span>	
<div style="display: flex; justify-content: space-between;"> <span>H-220</span> <span>70 00594</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
William W. Hughes			1-15-70 9 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Dukeland Nursing Home			A. STATE Maryland		
			B. COUNTY 1304		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3452 Auchentoroly Terrace					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-76	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realator		10B. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Hughes			14. MOTHER'S MAIDEN NAME Susan Cobbs		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-7983	17. INFORMANT Mr. Eugene Hughes 3452 Auchentoroly Ter.		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anteriosclerotic C.V.D.</p> <p>(B) Old age DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 12, 1945 to January 15, 1970, that (I) (we) last saw the deceased alive on January 10, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell, M.D.				23B. DATE SIGNED Jan. 17, 1970	
23C. PHYSICIAN'S NAME (Type) C R Campbell		23D. ADDRESS 1618 W. North Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-19-70	24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR 70 00594		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Avenue	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-240		BALTIMORE CITY HEALTH DEPARTMENT		70 00595	
BIRTH NO.		70 00595		REG. NO. 70 00595	
1. NAME OF DECEASED (Type or Print) <b>TAEWELL, HOWARD</b>			2. DATE AND HOUR OF DEATH <b>1. 11. 70 5 08 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> <b>1514 Divison Street</b> <b>Baltimore, Maryland 21217</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2015 McCulloh Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-4-97</b>	9. AGE (in years, last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Cement Finisher</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>William Tazewell</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Ellen Rowe</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>220-09-8806</b>			17. INFORMANT ADDRESS <b>Mrs. Cynthia Thompson- 2015 McCulloh St.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>599.8 21 303.2</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gram negative Septicemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Urinary Tract Infection</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Alcoholism</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>12-29 1968</b> to <b>1-11 1970</b> that (I) (we) last saw the deceased alive on <b>1-10 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>M. J. JAVARD</b>			23B. DATE SIGNED <b>1-11-70</b>		23C. PHYSICIAN'S NAME (Type) <b>M. JAVARD</b>
23D. ADDRESS <b>1514 Divison Street Baltimore, Md/</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1-17-70</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Shiloh Baptist Cemetery</b>		
24D. LOCATION (City, town, or county) (State) <b>Gloucester Co., Va.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		
25B. NAME OF REGISTRAR <b>John E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Nutter Funeral Home 3035 W. North Avenue</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325		70 00596		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00596	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ginyard Watson				2. DATE AND HOUR OF DEATH 1-10-70 12:55 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1506			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-25-00		9. AGE (In years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Revere				10B. KIND OF BUSINESS OR INDUSTRY Copper and Brass		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Lewis Watson			
14. MOTHER'S MAIDEN NAME Millie Rivers				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 248-03-4670				17. INFORMANT Mrs. Sarah Watson - Wife -			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism amputation of leg arteriosclerotic gangrene 1 ha 2 days (48 hrs) 1 week DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Generalized arteriosclerosis 19. DATE OF OPERATION 1-8-70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 1-8-70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) 1 Month 1 Day 1 Year 1 Hour 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from 11-19-69 19 to 1-10-70 19 that (I) (we) last saw the deceased alive on 1-10-70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. C. CLAY, M.D. 23B. DATE SIGNED 1-10-70				23C. PHYSICIAN'S NAME (Type) E. C. CLAY, M.D. 23D. ADDRESS Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-15-70 24C. NAME OF CEMETERY OR CREMATORY Western Star Cemetery 24D. LOCATION (City, town, or county) (State) Catonsville Balto. Co., Md				25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

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<p><b>D-152</b>      <b>70 00597</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>70 00597</b></p>			
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Dobbins, Elizabeth</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>1-12-70</b>      <b>4:35 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39</b>      <b>Provident Hospital</b> <b>1514 Divison Street</b> <b>Baltimore, Maryland 21217</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b>      <b>B. COUNTY</b> <b>Maryland</b></p> <p><b>C. CITY OR TOWN</b>      <b>D. INSIDE CITY LIMITS?</b> <b>Baltimore</b>      YES <input checked="" type="checkbox"/>      NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <b>604 Gold Street</b></p>	
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. RACE</b> <b>Negro</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>      <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>10/31/82</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Pvt Family</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>George Morgan</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Addie ?</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>216-09-9057</b></p>	
<p><b>17. INFORMANT</b> <b>D. Mrs. Maude Wilkerson</b></p>		<p><b>ADDRESS</b> <b>1326 Stockton</b></p>	
<p><b>18. CAUSE OF DEATH</b> <b>440.9 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Arteriosclerosis</b></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Malnutrition &amp; Dehydration</b> <b>(C) Family</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <b>No</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., In or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p><b>21E. INJURY OCCURRED</b> <b>White At</b> <input type="checkbox"/>      <b>Not White At</b> <input type="checkbox"/> <b>Wak</b>      <b>At Wak</b> <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>1-8-70</u> 19<u>  </u> to <u>1-12-70</u> 19<u>  </u> that (I) (we) last saw the deceased alive on <u>1-12-70</u> 19<u>  </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Elijah B. Saunders</b></p>		<p><b>23B. DATE SIGNED</b> <b>Jan. 13, 1970</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>SAUNDERS</b></p>		<p><b>23D. ADDRESS</b> <b>1514 Divison Street Baltimore, Md.</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>1/16/70</b></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Mt Auburn Cemetery</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Md</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 19 1970</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. [unclear]</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>Nutter Funeral Home</b></p>		<p><b>ADDRESS</b> <b>3035 W. North Avenue</b></p>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00598</u>	
W-452 70 00598		CERTIFICATE OF DEATH	
BIRTH NO. <u>W-452</u>		2. DATE AND HOUR OF DEATH <u>Jan. 15, 1970 9:30 P. M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Elzie WALLINGTON</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1603</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>833 N. Fulton Ave. #17</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Retired</u>		8. DATE OF BIRTH <u>7/5/08</u> 9. AGE (In years last birthday) <u>61</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>General Refractoris</u>		11. BIRTHPLACE (State or foreign country) <u>NC</u>	
13. FATHER'S NAME <u>John Wallington</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1943-1945</u>		14. MOTHER'S MAIDEN NAME <u>Enima Smith</u>	
16. SOCIAL SECURITY NO. <u>236-09-1684</u>		17. INFORMANT ADDRESS <u>Mrs. Lillian Wallington 833 N. Fulton Ave.</u>	
18. <u>532.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Peritonitis + myoc infarct.</u> (C) <u>Perforated duod ulcer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>1-13-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Peritonitis</u>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> 19 <u>70</u> to <u>Jan 15</u> 19 <u>70</u> that (I) <u>last</u> saw the deceased alive on <u>Jan 15</u> 19 <u>70</u> and that (in my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.			
23A. SIGNATURE <u>Meesen</u>		23B. DATE SIGNED <u>Jan 15, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr Michael MEESEN</u>		23D. ADDRESS <u>SINAI HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-70</u>	
24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly</u>	
25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>		ADDRESS <u>3035 W. North Ave.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
J-250 70 00599		70 00599		
1. NAME OF DECEASED (Type or Print) <b>JACKSON, GEORGE</b>		2. DATE AND HOUR OF DEATH <b>1/12/70 at 1.20 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1513</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>2808 BOARMAN AVE</b>		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/93</b>	9. AGE (in years last birthday) <b>76 1/2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Davison Trucking Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-1215</b>		17. INFORMANT <b>Mrs. Leona H. Jackson 2808 Boarman Ave.</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/2.4 I</b> <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC BRAIN SYNDROME</b> <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>GOUT ? RHEUMATOID ARTHRITIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12/28/69</b> 19 <b>69</b> to <b>1/12</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/12/1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		23D. ADDRESS <b>M.D.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>
24D. LOCATION <b>Baltimore, Md</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home 3035 W. North Ave.</b>

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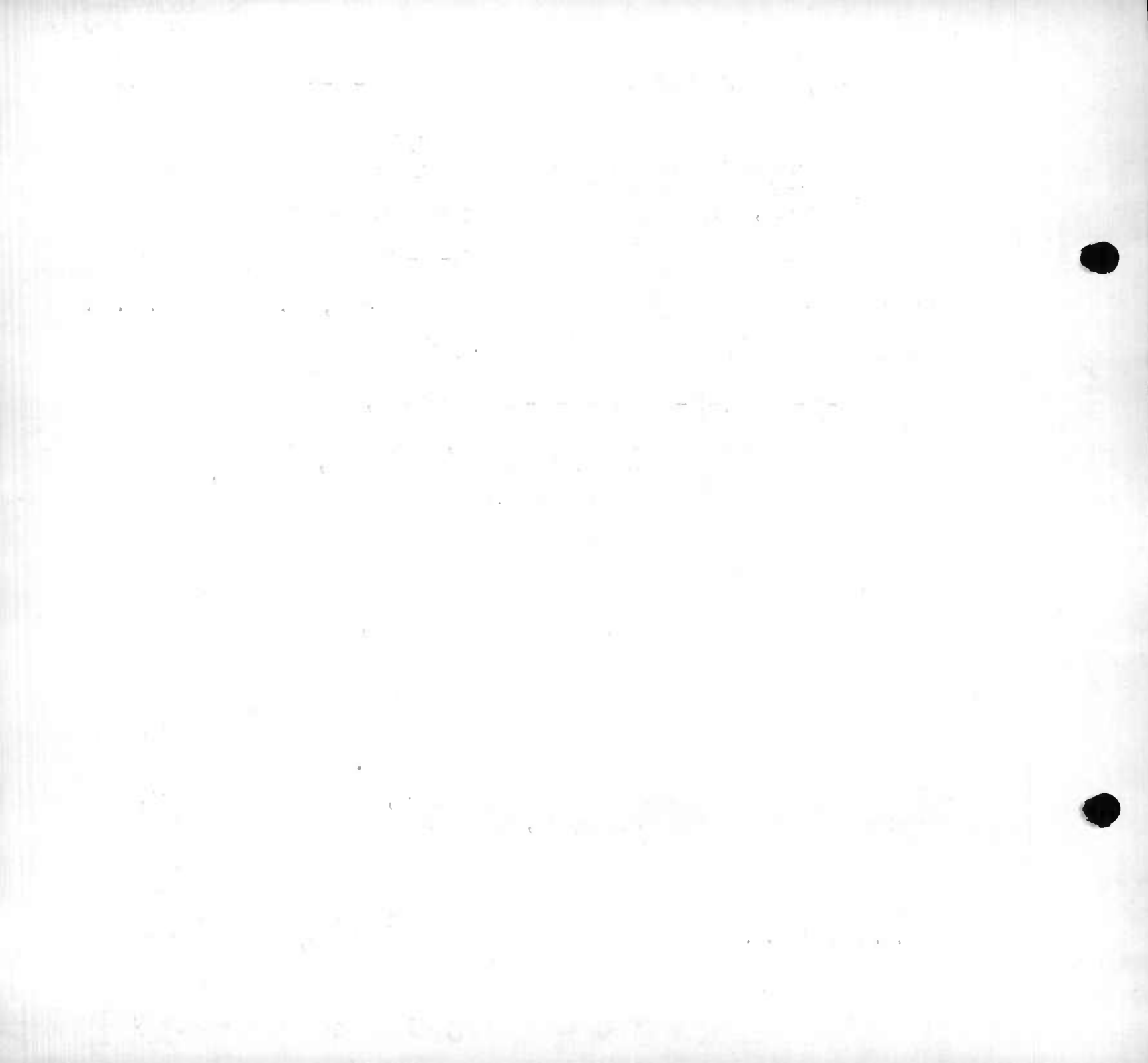
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650 BIRTH NO.		70 00600		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00600	
1. NAME OF DECEASED (Type or Print) <b>GREEN, Raymond Edward</b>				2. DATE AND HOUR OF DEATH <b>1-17-70 1:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1603</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1614 West Franklin Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-17</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Howard County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Charles Green</b>			14. MOTHER'S MAIDEN NAME <b>Mamie Howard</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-7-44 to 5-10-46</b>		
16. SOCIAL SECURITY NO. <b>212-18-09-18</b>			17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>				ADDRESS
18. I <b>162.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Carcinoma of Lung, right upper lobe with metastasis to the mediastinum, periaorta, peri-portal nodes and liver</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Atherosclerosis of aorta, mild</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>December 30, 1969</b> to <b>January 17, 1970</b> , that <b>X</b> (we) last saw the deceased alive on <b>January 17, 1970</b> and that in <b>X</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) <b>not</b> view the body after death.							
23A. SIGNATURE <b>M.G. Jewell M.D.</b>				23B. DATE SIGNED <b>1-17-70</b>		23C. PHYSICIAN'S NAME (Type) <b>M.G. Jewell M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burn</b>		24B. DATE <b>1/22/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1970</b>		25B. NAME OF REGISTRAR <b>John E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Don [Signature]</b>		ADDRESS <b>635 E. 9th St</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00601</u>
BIRTH NO. <u>70 00601</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ELIZABETH L. SLADE</u>		2. DATE AND HOUR OF DEATH <u>4-15-70 1/13/70 4:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1201</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hospital</u> <u>45</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4000 Lunkwood Rd.</u>		
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1879</u>	9. AGE (In years last birthday) <u>90</u> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Col. William H. Love</u>		
14. MOTHER'S MAIDEN NAME <u>Mary A. Crangle</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>46-48-36148</u>		17. INFORMANT <u>Wm. H. L. Slade (son)</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Fractured left femur</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Fractured left femur</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>4000 Lunkwood Rd.</u>		
21D. TIME OF INJURY (APPROX.) <u>11-15-69 8:15</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>fell at home</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>12-8-1969</u> to <u>1/13-1970</u> , that (I) (we) last saw the deceased alive on <u>1/13-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>David J. Tiller</u>		23B. DATE SIGNED <u>1/13/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>David J. Tiller</u>		23D. ADDRESS <u>222 Stevenson Ln Balt. Md. 21212</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/15/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>	24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>H. W. Jenkins &amp; Sons Co.</u>		
		25C. FUNERAL DIRECTOR ADDRESS <u>1905 York Rd. Balto., Md. 21212</u>		

Rec FROM. M.E OFFICE - 11/19/70



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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
BIRTH NO. 70 00602				CERTIFICATE OF DEATH		70 00602	
1. NAME OF DECEASED (Type or Print) <u>James William Shank SR</u>				2. DATE AND HOUR OF DEATH <u>1/16/70</u> <u>8:45 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>Baltimore, Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>BALLO. CO.</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>505 F Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/06/14</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Shank</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Welsh</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-07-3467</u>		17. INFORMANT <u>IDA SHANK 505 F. ST.</u>		ADDRESS	
18. CAUSE OF DEATH <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>COPD</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic shock</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>~2 hrs.</u> <u>Many yrs.</u> <u>Many yrs.</u>	
19A. DATE OF OPERATION <u>2/2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>70</u> to <u>1/16</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stuart Victor Grandis MD</u>				23B. DATE SIGNED <u>1/16/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Stuart Victor Grandis MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-20-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>DUNDALK MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>J. E. J. B. JR.</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WIERA SONS INC 401 S. CHESTER ST.</u>			

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FUNERAL DIRECTOR: IMPORTANT

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70 00603		BALTIMORE CITY HEALTH DEPARTMENT		70 00603	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>ADAM DOW</u>		2. DATE AND HOUR OF DEATH <u>1-18-70</u> <u>12:05 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GEN. HOSP</u> <u>43</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>704 ROUNDVIEW ROAD</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1919</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>EDGAR DOW</u>		14. MOTHER'S MAIDEN NAME <u>MARY COPELAND</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>248-26-6063</u>		17. INFORMANT <u>WIFE Mrs. Elsie Dow</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Profound Cardiovas. Collapse</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Atherosclerosis</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MIN</u> <u>HRS</u> <u>YRS</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-10-70</u> 19 <u>70</u> to <u>1-19</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald M. Wood</u>		23B. DATE SIGNED <u>1-19-70</u>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>SOUTH BALTO GEN.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F.H. 1701 Laurens St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

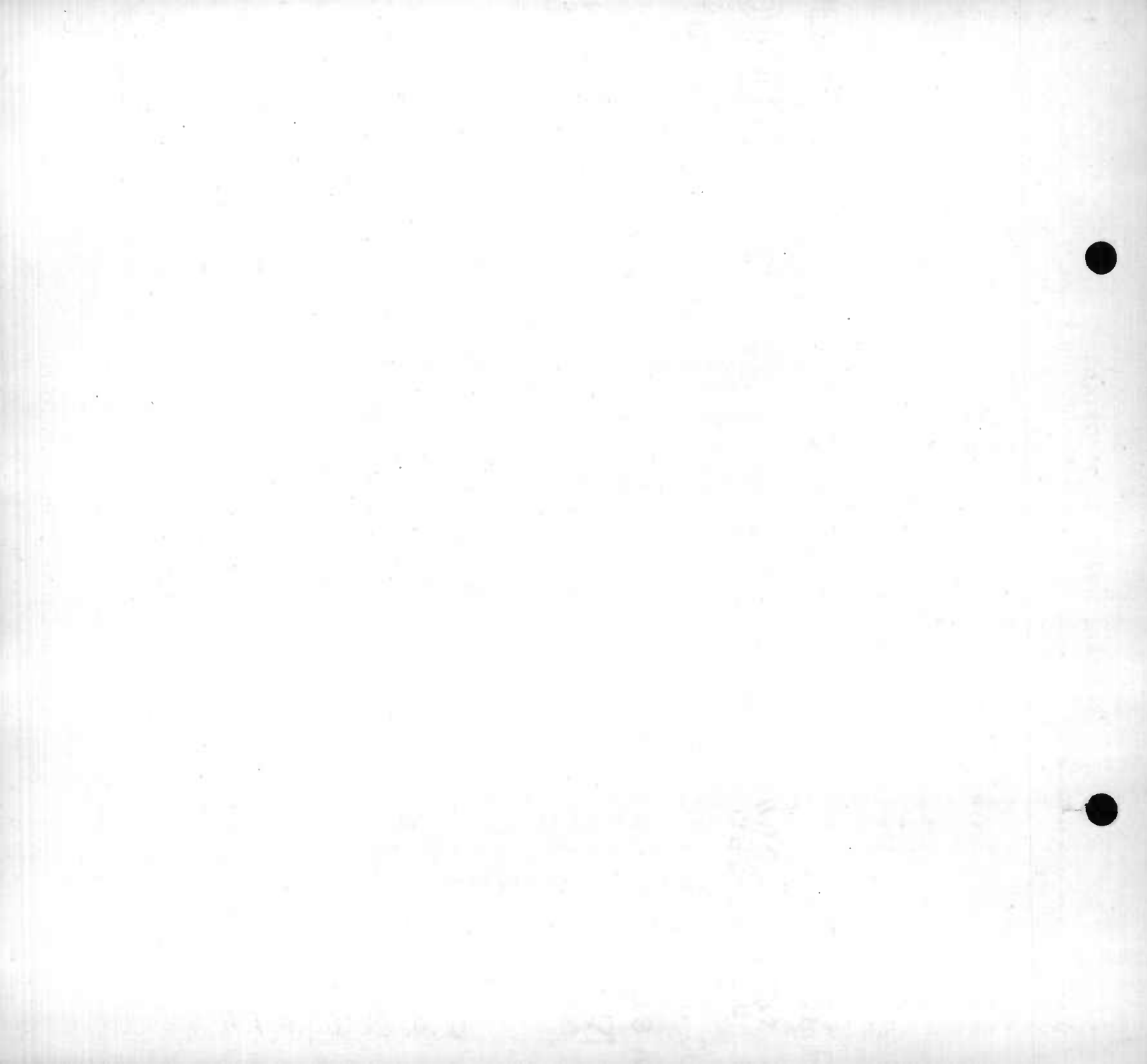
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00604</u>
BIRTH NO. <u>70 00604</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>TNEZ Brooks</u>		2. DATE AND HOUR OF DEATH <u>1-16-70</u> <u>10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles Gen Hosp</u>		A. STATE <u>md</u> B. COUNTY <u>1901</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>49</u>		E. STREET AND NUMBER <u>237 N. FULTON AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-99</u>	9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>N.C., Warsaw</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>ALEXANDER Williams</u>		
14. MOTHER'S MAIDEN NAME <u>HAKCISSUS Williams</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>213-34-2666</u>		17. INFORMANT <u>ESSIE CONLEY</u> ADDRESS <u>same</u>		
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>carcinoma RT breast 1 y</u> until metastases to the lung		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>until metastases to the lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>—</u>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>12-13</u> <u>1969</u> to <u>1-16</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. Melvinio Ventura</u> DEGREE <u>—</u>				23B. DATE SIGNED <u>1-16-70</u>
23C. PHYSICIAN'S NAME (Type) <u>DR. MELENCIO VENTURA</u> DEGREE <u>—</u>				23D. ADDRESS <u>NORTH CHARLES GEN Hosp</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/21/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Brooks Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hyden, N.C.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>119 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>MORTON E. Dyett</u> ADDRESS <u>1701 Laurels St.</u>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00605</u>
BIRTH NO. <u>70 00605</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>ROBERT E. LEE</u>		2. DATE AND HOUR OF DEATH <u>1/16/70</u> <u>5<sup>15</sup> AM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1603</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1121 N. FULTON</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-19</u>	9. AGE (In years lost birthday) <u>50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth-Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Burgaw, North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT William Lee</u>		
14. MOTHER'S MAIDEN NAME <u>MARGARET Lee</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Naomi Lee</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION ~ 15 min</u> <u>UREMIA</u> <u>CHRONIC RENAL FAILURE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1/11/70</u> to <u>1/16/70</u> , that (I) (we) last saw the deceased alive on <u>1/16/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert S. Weinberg M.D.</u>		23B. DATE SIGNED <u>1/16/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT S. WEINBERG</u>
23D. ADDRESS <u>THE JOHNS HOPKINS HOSP.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>1/20/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Barton D. Dyett F.H.</u>
ADDRESS <u>1701 Lakewood St.</u>				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00606	
70 00606				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Miss Cynthia R. Maybin		2. DATE AND HOUR OF DEATH Jan. 16, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		M. 2004	
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 34 2511 W. Pratt St.		21223			
5. SEX Female	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-16-53	9. AGE (In years last birthday) 16	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY Western High Sch.		11. BIRTHPLACE (State or foreign country) Maryland, Balto.	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME James Maybin		14. MOTHER'S MAIDEN NAME Flossie Beans (same)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mr. James Maybin 2511 W. Pratt St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic coma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute yellow atrophy liver		(B) DUE TO, OR AS A CONSEQUENCE OF: Infectious hepatitis liver			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1-14-1970 to 1-16-1970 that (1) (we) last saw the deceased alive on 1-16-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Abbas M.D.				23B. DATE SIGNED 1-16-70	
23C. PHYSICIAN'S NAME (Type) M. Abbas M.D.				23D. ADDRESS Bon Secours Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/70		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem.	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 19 1970		24F. NAME OF REGISTRAR R. E. Taber, M.D.	
24G. FUNERAL DIRECTOR M. Abbas		24H. ADDRESS 1701 Laurens St			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EMMA WEBSTER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>January 16, 1970</b>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>226 N. Monroe Street</b>		3. DATE PRONOUNCED DEAD <b>January 16, 1970</b>		Month Day Year		Hour M. <b>2:20 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>2001</b>					
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>8-15-1891</b>		10. AGE (In years) <b>78</b>		11. BIRTHPLACE (State or foreign country) <b>Amelia Co., Virginia</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Gafford</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Annie Gafford</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>217-38-2304</b>		18. INFORMANT <b>Mr. Freddie Webster</b>		ADDRESS <b>226 N. Monroe Street</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>412.4</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 18, 1970</b> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	



1  
3-520

70 00608

BALTIMORE CITY HEALTH DEPARTMENT

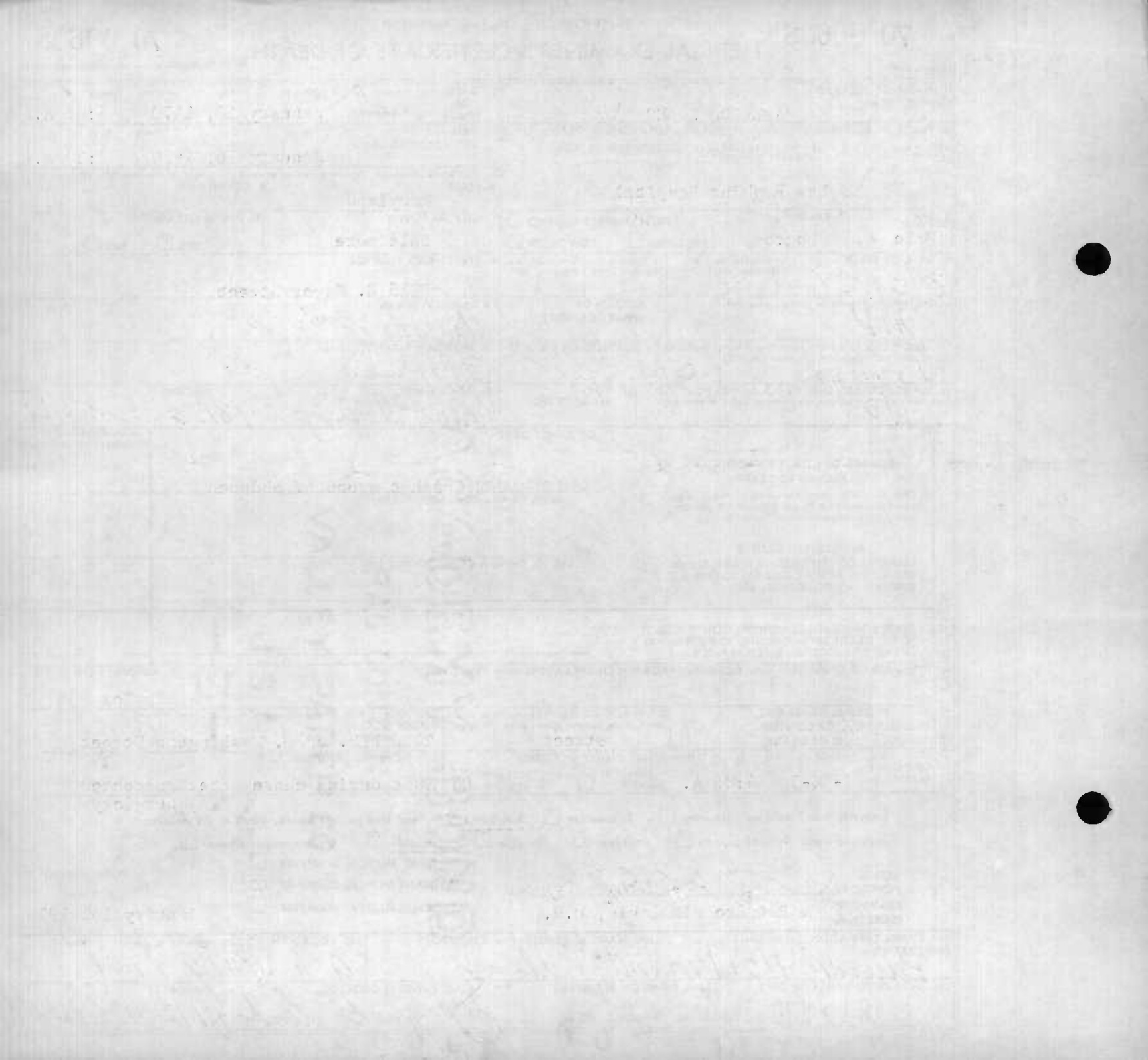
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00608

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ARLANDO JONES Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 16, 1970</b>		Hour <b>6:30 A.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 16, 1970</b>		Hour <b>6:30 A.M.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>8/21/51</b>		10. AGE (In years lost birthday) <b>18</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Arlando Jones Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>
15. MOTHER'S MAIDEN NAME <b>Florence Redd</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Karen Pittman Jones</b>		19. CAUSE OF DEATH <b>E965X</b>		ADDRESS <b>1815 E. Eager St</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Gunshot wound of abdomen</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____ DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <b>2/21/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2000 blk. of N. Washington Street</b>
22D. TIME OF INJURY (APPROX.) <b>1-16-70 4:06 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during chase after suspected burglary</b>
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 16, 1970</b>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt. Calvary</b>
24D. LOCATION (City, town or county) (State) <b>a.d. County, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>
25C. FUNERAL DIRECTOR <b>Joseph B. Locks</b>		25D. ADDRESS <b>13047 Central Ave</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00609	
G-416 70 00609		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or print) <i>Minnie Gilbert</i>		2. DATE AND HOUR OF DEATH <i>January 15, 1970 6:40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>city</i>		C. CITY OR TOWN <i>Balto</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Nurs. Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 1213 Light St</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>6/8/08</i>		9. AGE (In years last birthday) <i>61</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Mt. Gillard, N. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Peter Burton</i>		14. MOTHER'S MAIDEN NAME <i>Kella ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>243-42-8145</i>		17. INFORMANT <i>Louise Small - 2035 E. Eager St.</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i> (B) <i>A.S.C.V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1/6 1970</i> to <i>1/15 1970</i> , that (I) (we) last saw the deceased alive on <i>1/13 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Joseph S. Blum MD.</i>	
23B. DATE SIGNED <i>1/16/70</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM MD.</i>		23D. ADDRESS <i>1115 N. CALVERT ST.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-19-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Green Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>High Point, N. C.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones MD.</i>	
25C. FUNERAL DIRECTOR <i>L. B. Haslip</i>		25D. ADDRESS <i>206 - 4th St., High Point, N. C.</i>		25E. DATE <i>1-19-70</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

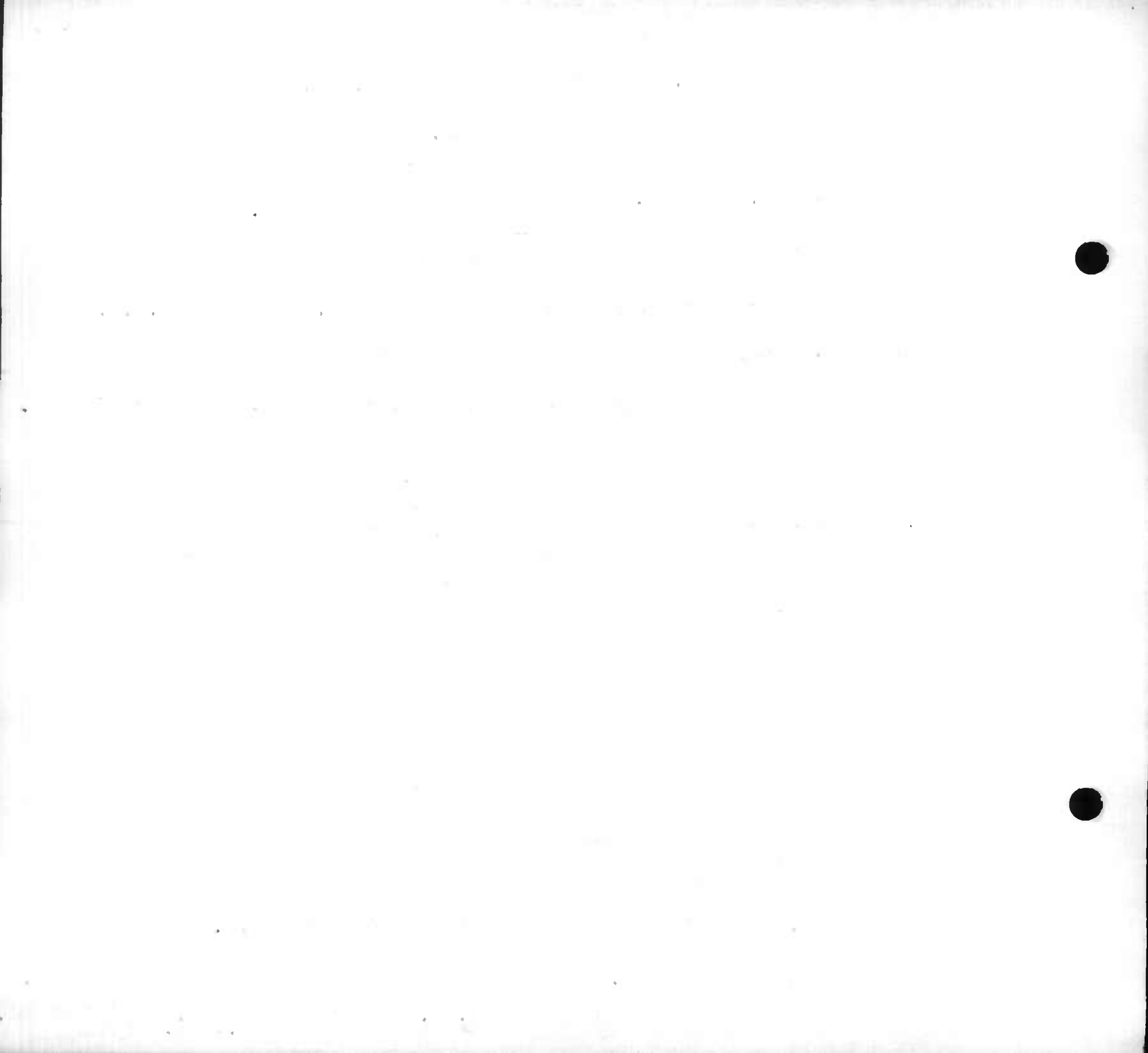
<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. <u>70 00610</u>	
1. NAME OF DECEASED (Type or Print) <u>MARTIN, JOSEPH E</u>		2. DATE AND HOUR OF DEATH <u>1/18/70</u> <u>12:30 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 MARYLAND GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2711</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>231 HONELAND SOUTHWAY</u>	
5. SEX <u>M</u>	6. RACE <u>CAU</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7/18/22</u>
9. AGE (In years last birthday) <u>47</u>		If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ANCHOR PACKING</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOS. MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET McEWEE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII Army</u>		16. SOCIAL SECURITY NO. <u>166-12-5286</u>	17. INFORMANT <u>Joseph E. Martin, Jr.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY + CIRCULATORY COLLAPSE</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>UPPER G-I HEMORRHAGE, MASSIVE 2 days</u> (C) <u>[REDACTED]</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>1/15/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GI HEMORRHAGE</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>JAN 13</u> 19 <u>70</u> to <u>JAN 18</u> 19 <u>70</u> , that (1) (we) last saw the deceased alive on <u>JAN 18</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>David M. Cook</u>		23B. DATE SIGNED <u>1/18/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. David M. Cook</u>		23D. ADDRESS <u>MARYLAND GENERAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>Jan 19 1970</u>		25B. NAME OF REGISTRAR <u>2268 Feb 7 70</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>		25D. ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>	

Funeral Home & Telephone Directory  
list address as 321 Homeland  
Sanctuary

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					REG. NO. <u>70 00611</u>					
BIRTH NO. <u>P-600</u>		1. NAME OF DECEASED (Type or Print) <u>Richard H. Perry</u>			2. DATE AND HOUR OF DEATH <u>Jan. 17, 1970</u> <u>6 05</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Century Nursing Home</u> <u>102 N. Paca St.</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2748</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1229 Evesham Ave.</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/1906</u>		9. AGE (in years last birthday) <u>63</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
13. FATHER'S NAME <u>Thomas E. Perry</u>					14. MOTHER'S MAIDEN NAME <u>Nina Cannon</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>216-01-4942</u>		17. INFORMANT ADDRESS <u>Miss June Chapman, 1229 Evesham Ave.</u>			
18. <u>250.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Cardio Respiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Art C V D</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Heart Failure</u> <u>Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>Mar 29</u> 19 <u>66</u> to <u>Jan 17</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>Jan 17</u> 19 <u>70</u> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (1) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.										
23A. SIGNATURE <u>Willard Applefeld</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. Willard Applefeld</u>						23B. DATE SIGNED <u>1/17/70</u>		23D. ADDRESS <u>6615 Reisterstown Rd.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/20/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			25B. NAME OF REGISTRAR <u>John E. Fisher</u>			25C. FUNERAL DIRECTOR <u>H. V. Jenkins &amp; Sons Co.</u>			25D. ADDRESS <u>4905 York Rd Balto., Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

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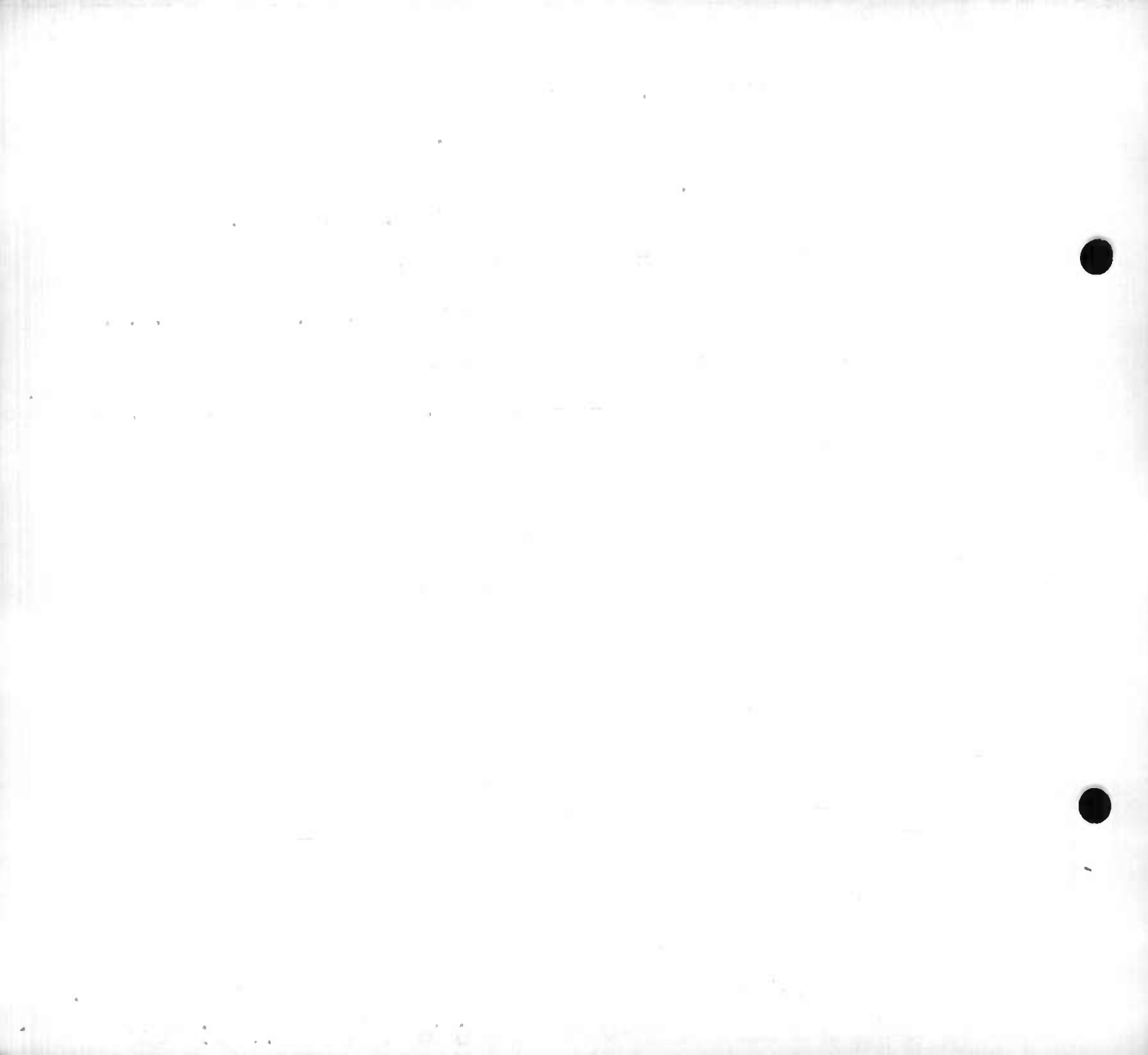
L-100		70 00612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00612	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DR. GEORGE D. LIPPY</b>				V/17/70 8 46 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
44 UNION MEMORIAL HOSPITAL.				MARYLAND		1307	
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
M		W		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER			
				3730 TUDOR ARMS AVENUE			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
PHYSICIAN		MEDICINE		9/22/98		71	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
CARROLL CO. Md.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HARRY LIPPY				(UNKNOWN) REED			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				212-40-6508			
17. INFORMANT				ADDRESS			
MRS MADELINE LIPPY				3730 TUDOR ARMS AVENUE BALTIMORE MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				~ 2 hours.			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CEREBRAL HEMORRHAGE			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7:10 AM 1/17 1970 to 8:46 AM 1/17 1970 that (I) (we) lost saw the deceased alive on 1/17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Anne L. Leddy M.D.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Anne L. Leddy M.D.				Union Memorial Hospital Baltimore Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/20/70		Greenmount		Greenmount, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
JAN 19 1970		Robert E. Jenkins		H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			

Mr. J. H. Smith

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00613</u>	
<u>K-235</u> BIRTH NO. <u>70 00613</u>		1. NAME OF DECEASED (Type or Print) <u>Alice G. Kastner</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Northway Apts.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3700 N. Charles St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1885</u> 9. AGE (in years lost birthday) <u>84</u> If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Leitch Graham</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Paterson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-8511</u>		17. INFORMANT <u>Mrs. Margaret Singley, 611 W. University Pkwy.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes</u> <u>Gangrene of rd foot</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>5 years</u> <u>6 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1946</u> to <u>1/17 1970</u> that (I) (we) last saw the deceased alive on <u>1/16 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Franklin E. Leslie</u> DEGREE				23B. DATE SIGNED <u>1/17/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u> DEGREE				23D. ADDRESS <u>3501 St Paul St. - Baltimore - Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>		24B. DATE <u>1/19/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1970</u>			
25B. NAME OF REGISTRAR <u>E. J. Baker, D.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 1905 York Rd. Balto., Md. 21212</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-126		70 00614		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00614	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HOFFECCKER, MARIE B.</b>		2. DATE AND HOUR OF DEATH <b>1/16/70 4:45A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND, BALTO</b> B. COUNTY <b>1201</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEM. HOSP</b> <b>44 BALTO., MD</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3800 EAST EBBWAL RD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/91</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NSW</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS W. BURCH</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE REGISTER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-1012</b>		17. INFORMANT <b>MONKTON, MD 21111</b> <b>THOMAS HOFFECCKER</b>			
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CA BREAST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>pulmonary debility for metastatic</b> <b>Ca. esophagus and colon.</b> <b>M.M.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/8/70</b> to <b>1/16/70</b> that (I) (we) last saw the deceased alive on <b>1/16/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harvey B. Sherman, D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/16/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARVEY B. SHERMAN</b>				23D. ADDRESS <b>UNION MEM. HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/70</b>		24C. NAME of CEMETERY or CREMATORY <b>London Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 15 1970</b>		25B. NAME OF REGISTRAR <b>70 00614</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

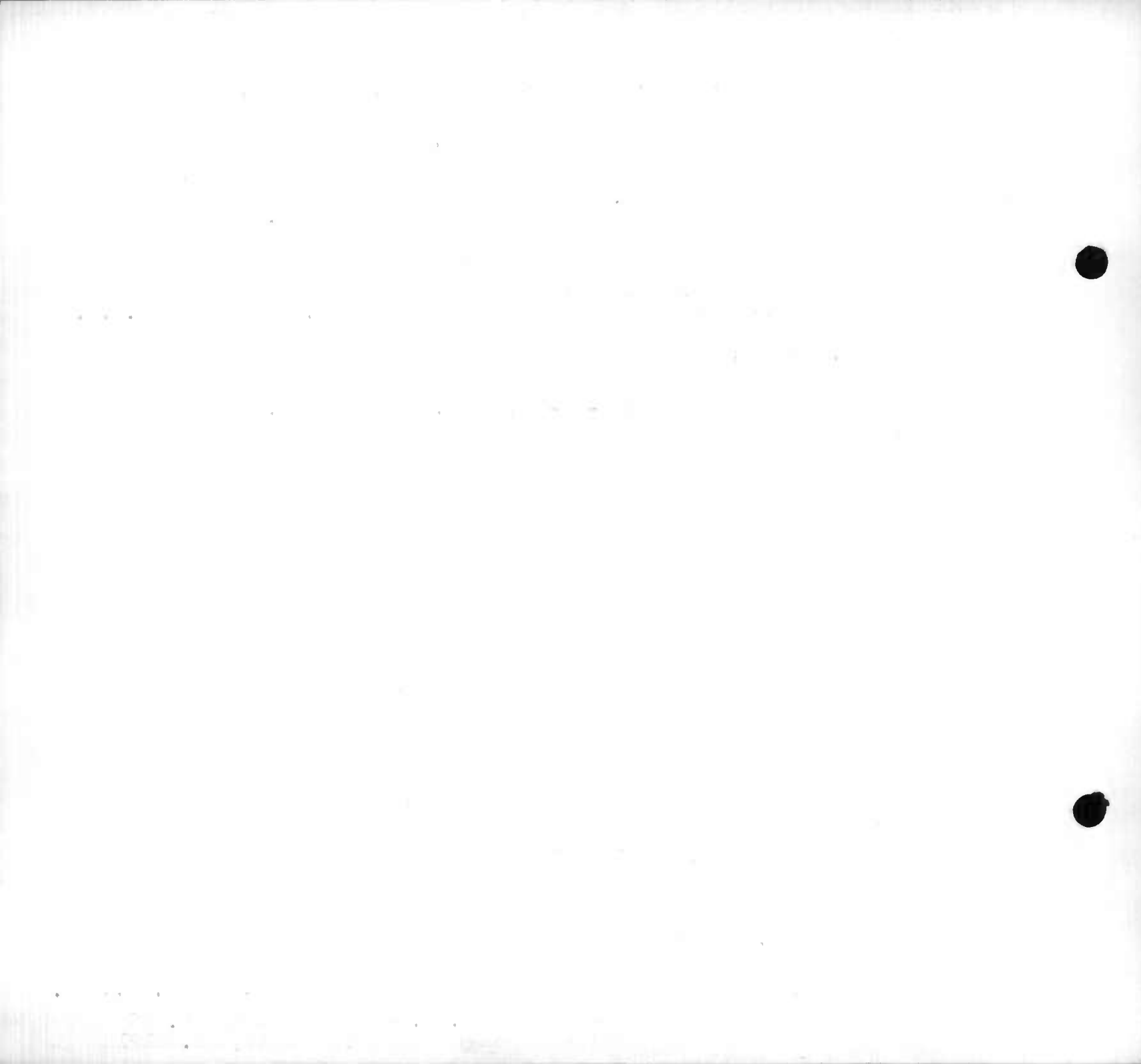
For the purpose of the  
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John V. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

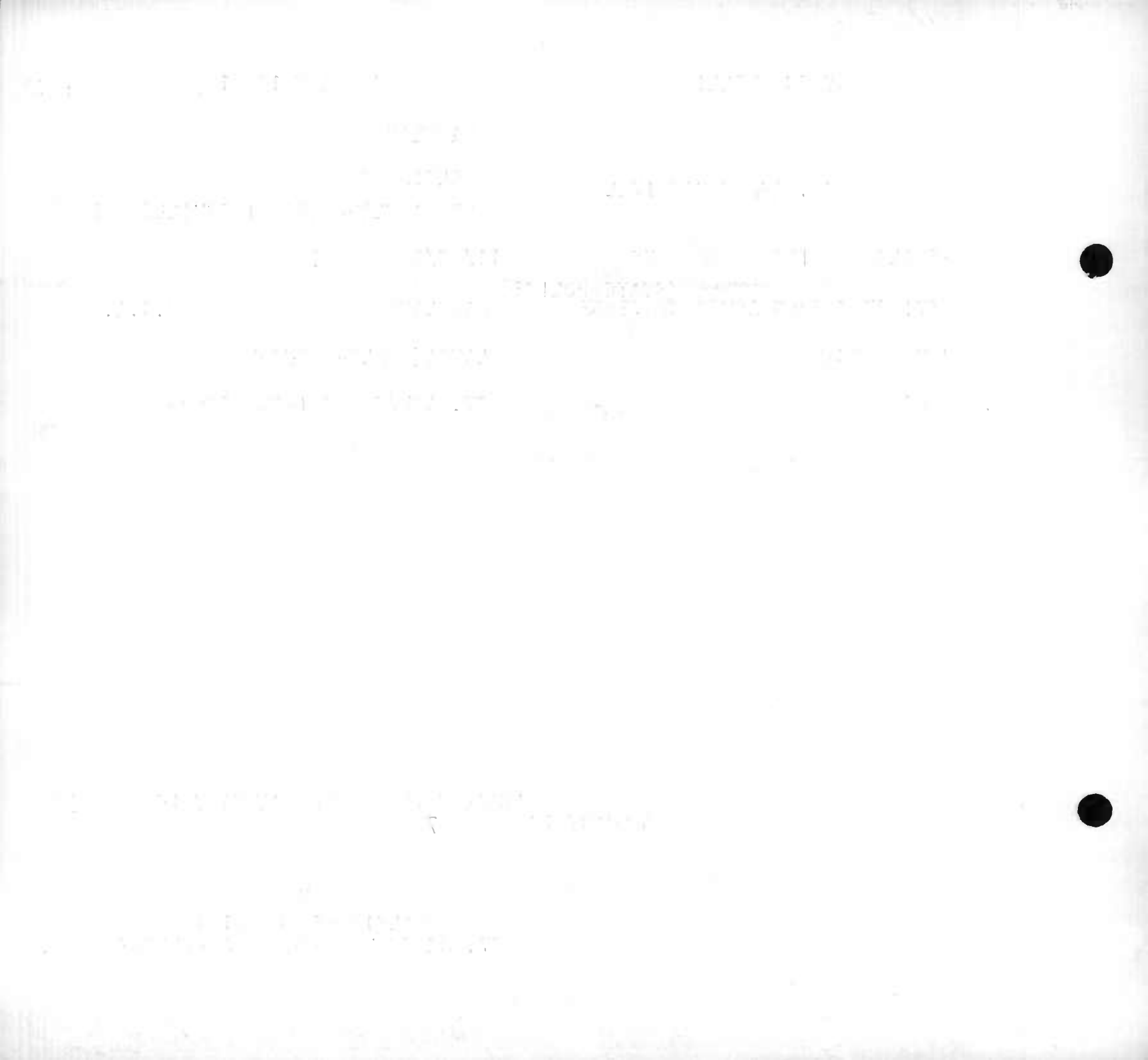
BIRTH NO. <b>I-246</b>				BALTIMORE CITY HEALTH DEPARTMENT				70 00616				REG. NO. <b>70 00616</b>			
1. NAME OF DECEASED (Type or Print) <b>Walter Vincent Iglehart</b>								2. DATE AND HOUR OF DEATH <b>January 16, 1970</b> <b>11 P. M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>80 5629 Govane Ave.</b>								4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2778</b>							
								C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
								E. STREET AND NUMBER <b>5629 Govane Ave.</b>							
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/13/1898</b>		9. AGE (in years last birthday) <b>71</b>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Security Guard</b>								10B. KIND OF BUSINESS OR INDUSTRY <b>Canton Railroad</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>															
13. FATHER'S NAME <b>Howard B. Iglehart</b>								14. MOTHER'S MAIDEN NAME <b>Gertrude Fallon</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>								16. SOCIAL SECURITY NO. <b>213-03-3240</b>				17. INFORMANT <b>Mrs. Bernadine E. Iglehart (Same)</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Recurrent Myocardial infarct seconds</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>9 years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).															
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>no</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this-hospital) attended the deceased from <b>Sept 19 1968</b> to <b>Jan 16 1970</b> that (I) (we) last saw the deceased alive on <b>Jan 5 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>Frederick J. Vollmer</b>								23B. DATE SIGNED <b>1-19-70</b>							
23C. PHYSICIAN'S NAME (Type) <b>Frederick J. Vollmer</b>								23D. ADDRESS <b>6100 York Road</b>							
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/20/70</b>				24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>				24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Gabe, M.D.</b>				25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Rd Balto, Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 00617	
H-520 70 00617				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) HYNES, NELLIE D				2. DATE AND HOUR OF DEATH JANUARY 15, 1970 1:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 27 MARYLAND AVE PIKESVILLE 21208			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/99	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRE STENOGRAPHER STATE OF MD			10B. KIND OF BUSINESS OR INDUSTRY (STATE POLICE)		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN DUNCAN				
14. MOTHER'S MAIDEN NAME LAURA (DUNLAP) DUNCAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				
16. SOCIAL SECURITY NO. unknown			17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio gene - shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Complete heart block - 1 hour - (B) DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial Infarction 4 days - (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour - 1 hour - 4 days -							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 14 1970 to JANUARY 15 1970 that (I) (we) last saw the deceased alive on JANUARY 15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alexander Kuyis M.D. DEGREE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ALEXANDER KUYIS DEGREE	
23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.				23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

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E-120		70 00618		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00618	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Bettie Epps</b>			
2. DATE AND HOUR OF DEATH <b>13 Jan 70 11:15 P M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hosp</b>				A. STATE <b>MD</b>		B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1708 Barclay Street</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-15-10</b>		9. AGE (in years last birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>Walter Scott</b>				14. MOTHER'S MAIDEN NAME <b>Liza Jackson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Chart</b> ADDRESS <b>Edith Young 3745 Beta St. San Diego, Calif.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED (White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1/9 1970</b> to <b>1/13 1970</b> that (1) (we) last saw the deceased alive on <b>1/13 1970</b> and that (in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (he) (did not) view the body after death.							
23A. SIGNATURE <b>M. G. M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/13/70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>Union Memorial Hosp.</b> DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-17-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		ADDRESS <b>1735 Harford Ave</b>	

From March 1st 1896

Balance

April 1st

May 1st

June 1st

B-631

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00619

BIRTH NO.

69-2/109

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS SHAWN BRADFORD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 15, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b> (DOA)		3. DATE PRONOUNCED DEAD Month Day Year <b>January 15, 1970</b>		Hour <b>9:56 A.M.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>11-17-69</b>		10. AGE (In years lost birthday) <b>1 1/2</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Bradford</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Fulton</b>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>		17. SOCIAL SECURITY NO. <b>none</b>
18. INFORMANT <b>Gertrude Lemon</b>		19. CAUSE OF DEATH <b>Sudden death in infancy</b>		20. ADDRESS <b>1122 Leadenhall St.</b>
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent causes</b>		22. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. DATE OF OPERATION <b>1-19-70</b>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		26. AUTOPSY? (Yes or No) <b>Yes</b>
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. HOW DID INJURY OCCUR?
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>11 17 69 11 15</b>		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. DATE SIGNED <b>January 15, 1970</b>
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
36. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		37. DATE <b>1-19-70</b>		38. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>
39. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		40. NAME OF REGISTRAR <b>E. E. Taylor, M.D.</b>		41. FUNERAL DIRECTOR <b>Charles A. Rice</b>
42. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		43. NAME OF REGISTRAR <b>E. E. Taylor, M.D.</b>		44. ADDRESS <b>661 W. Barre St.</b>

ACADEMY OF BORDO

D-230

70 00620

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00620

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLEO DOUGHTY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 15, 1970 9:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour January 15, 1970 9:45 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/29/47		10. AGE (In years last birthday) 22	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 1966-1968		17. SOCIAL SECURITY NO. 218-44-0934	
18. INFORMANT Mary E. Doughty		ADDRESS 2759 W. Fairmount Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2759 W. Fairmount Avenue		22F. HOW DID INJURY OCCUR? Apparently fell down stairs of home	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70	
24C. NAME OF CEMETERY or CREMATORY Tawcaw		24D. LOCATION (City, town, or county) (State) Summerton, S.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

ACADEMY BOMB

Box 1-11-6



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00621	
<div> <div>70 00621</div> <div>CERTIFICATE OF DEATH</div> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ELBERT, Waddell Henry</u>			
2. DATE AND HOUR OF DEATH		<u>17-Jan-70 12:21 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Md		1605	
<u>South Baltimore General Hospital</u>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
<u>413</u>		<u>Baltimore</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
<u>Male</u>		<u>Negro</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
<u>Cab Driver</u>				<u>4-22-05</u>	
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		If Under 1 Yr. Months Days	
<u>Maryland</u>		<u>64</u>		If Under 24 Hrs. Hours Min.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
<u>U.S.A.</u>		<u>Zora Elbert</u>			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
<u>Kateie Dixon</u>		<u>Unknown</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT			
<u>217-05-5922-A</u>		<u>Catherine Elbert (wife)</u>			
18. <u>430.0 I</u> CAUSE OF DEATH		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<u>Same</u>			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Subarachnoid Hemorrhage</u> 8 hrs			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Hypertension</u>			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>				<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <u>16-Jan</u> 19 <u>70</u> to <u>17-Jan</u> 19 <u>70</u> that (I) <del>(we)</del> lost saw the deceased alive on <u>16-Jan</u> 19 <u>70</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Richard E Fisher M.D.</u>				<u>17-Jan-70</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<u>Richard E Fisher M.D.</u>				<u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>BURIAL</u>		<u>1-21-70</u>		<u>ARBUTUS MEM. PK.</u>	
24D. LOCATION		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
<u>ARBUTUS, Md.</u>		<u>Robert E. Fisher, M.D.</u>		<u>Charles A. Rice</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>JAN 19 1970</u>		<u>Robert E. Fisher, M.D.</u>		<u>Charles A. Rice</u>	
25D. ADDRESS		25E. ADDRESS			
<u>661 W. Barre St.</u>		<u>661 W. Barre St.</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00622
BIRTH NO. 70 00622		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>JAMES B. SPRIGGS</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 16 1970 12:50 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1607</b>		
5. SEX <b>male</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>UNK.</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>EMMA SPRIGGS</b> ADDRESS <b>730 RAMSEY ST.</b>
18. <b>199.1</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>TERMINAL BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>INTESTINAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>POSSIBLY MALIGNANT TUMOUR</b>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 10 1970</b> to <b>JANUARY 16 1970</b> , that (I) (we) lost saw the deceased alive on <b>JANUARY 16 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <input checked="" type="checkbox"/>				
23A. SIGNATURE <b>Christos Dibranos</b>		23B. DATE SIGNED <b>JANUARY 16, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>CHRISTOS DIBRANOS, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-22-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>CHARLES A. RICE</b> ADDRESS <b>661 W. BARRE ST.</b>

OFFICE

WALTER

Letter on Hospital  
2-2-1914

Memorandum

Under

ENRICH STROGER

Yes, Mr. I

WALTER C. BARNETT

CHURCHMAN, 1001 10th Street

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

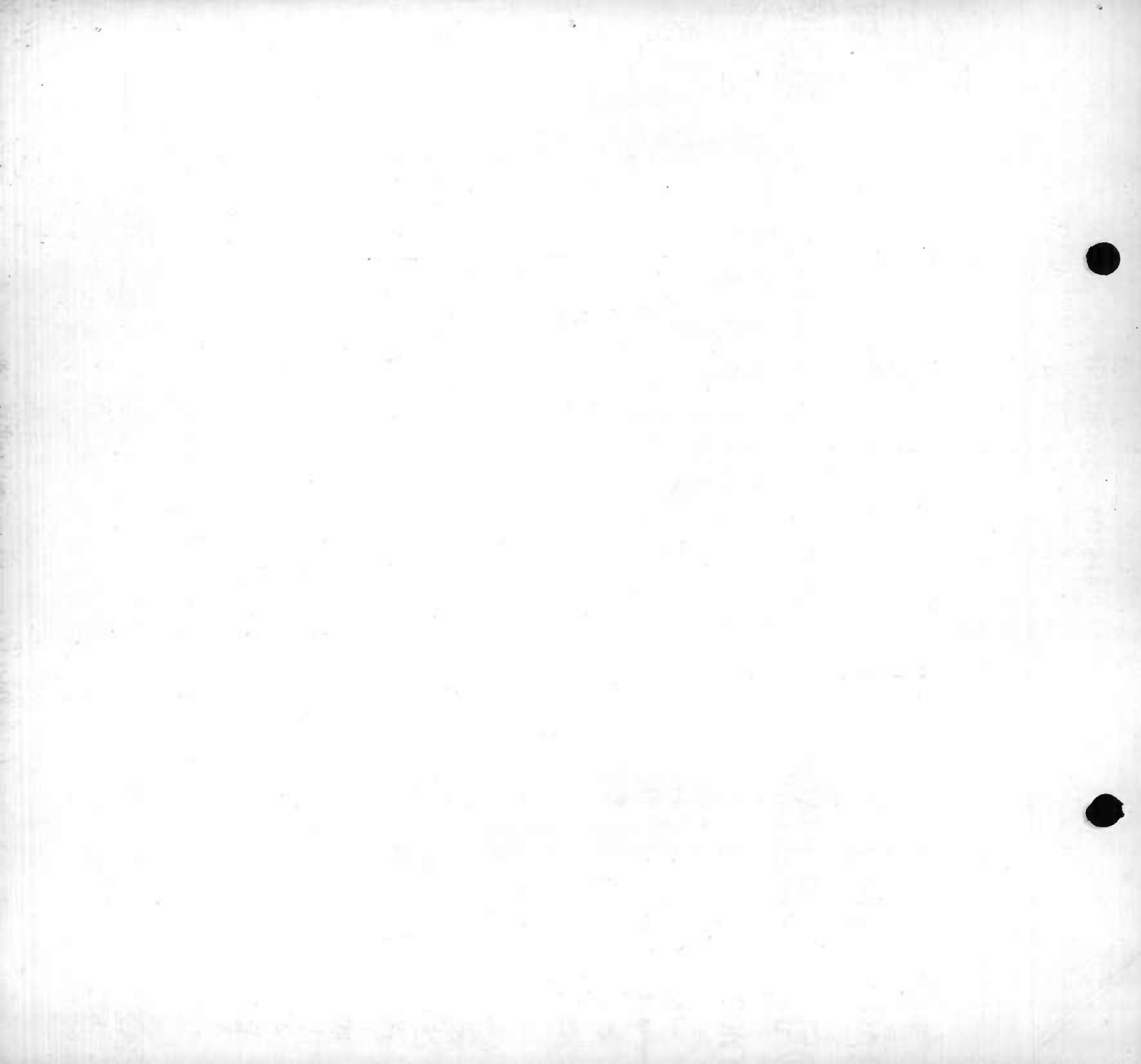
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-516		70 00623		70 00623	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KEM Berlin Virginia		Jan 15, 1970 11:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
276 Bowline Rd		Maryland		A.A. Co 52-00	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Claude W A Y		Maritta Mayley		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
W		218-26-1651		husband	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Ruptured middle cerebral aneurysm	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2		none		head	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		1-10-1970 to 1-15-1970			
that (I) (we) last saw the deceased alive on		1-15-1970 and that (in my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Frank J. Gillen MD		1-15-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANK J. GILLEN		Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/19/70		Lake View Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1970		Leonard J. Rueck Inc. Baltimore, Maryland		ADDRESS	

V. S. 153 1-20-70  
M. H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00624	
H-246 70 00624		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>MARY C. HESSLER</b>			2. DATE AND HOUR OF DEATH <b>1/17/70 6:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balt. City</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital 38</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>2/5/00</b> 9. AGE (In years last birthday) <b>69</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Albert Phillips</b>			14. MOTHER'S MAIDEN NAME <b>Ide Clares</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		
17. INFORMANT <b>Patricia Son - 706 Woodmont Rd.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>486 X I</b>			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Bilateral Pneumonia</b> (1)		
			(B) <b>Possible congestive pneumonia</b> (1)		
			(C) <b>Cardiac arrhythmia</b> (1)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2/1/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>70</b> to <b>1/17</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold J. Kaplan M.D.</b>				23B. DATE SIGNED <b>1/17/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>HAROLD J. KAPLAN M.D.</b>				23D. ADDRESS <b>U. of Md HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cem. Baltimore</b>	
24D. LOCATION (City, town, or county) <b>Md.</b>		24E. NAME OF REGISTRAR <b>John E. ...</b>		24F. FUNERAL DIRECTOR <b>John E. ...</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>John E. ...</b>	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 00625	
1. NAME OF DECEASED (Type or Print) <b>RICHARD VALENTINE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>834 N. Bond St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 12 70 12:30P. M.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>704</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>Aug 15, 02</b>		10. AGE (In years last birthday) <b>67</b>		E. STREET AND NUMBER <b>834 N. Bond St.</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Valentine</b>			
14A. USUAL OCCUPATION (Give kind of work done during a most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Agnes Evans</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>219-07-9286</b>		18. INFORMANT ADDRESS <b>Mrs. Mae Branch 1734 East Eager St.</b>			
19. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>1-12-70</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213 Marshall W. Jones, Jr.</b>			







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600		70 00626		BALTIMORE CITY HEALTH DEPARTMENT		70 00626	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>ANNA H Curry</u>				2. DATE AND HOUR OF DEATH <u>1-15-70</u> <u>12:35</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Conv'l. Center</u> <u>1213 Light Street.</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>26 42</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4209 Nicholas Ave.</u>							
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-09</u>	9. AGE (in years last birthday) <u>60</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HENRY H. Coale</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Duran</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>1426 Oakdale Rd</u> <u>Clifford Brandenburg Glen Burnie, Md</u>	
18. <u>432.9 x 125.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Cerebral Arteriosclerosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recent Carotid artery thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>225</u> <u>mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>Diabetes Mellitus</u>		<u>413</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) <u>(the hospital)</u> attended the deceased from <u>12-29</u> 19 <u>69</u> to <u>1-15</u> 19 <u>70</u> that <u>we</u> last saw the deceased alive on <u>1-15</u> 19 <u>70</u> and that <u>my</u> <u>our</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(we)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>H. C. Alvarez</u>				23B. DATE SIGNED <u>1/15/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. C. ALVAREZ, M.D.</u>				23D. ADDRESS <u>12095A Paul Street Balt 21205</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u>		25B. NAME OF REGISTRAR <u>Wm. Cook Brooks West Inc</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook Brooks West Inc</u>		ADDRESS <u>6212 Baltimore National Pike Balt. Md</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>S-632 70 00627</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>70 00627</b></p>			
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>Schwartz, Mrs. Anna I.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>JAN. 16, 1970 3 30 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p><b>CERTIFICATE AMENDED</b></p> <p>HOSPITAL OR INSTITUTION <b>1-26-70</b></p> <p>ADDRESS OR LOCATION <b>Keswick - 700 W. 40th St. 21211</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MARYLAND</b> B. COUNTY <b>1307</b></p> <p>C. CITY OR TOWN <b>Baltimore City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>700 W 40th Street</b></p>	
<p>5. SEX <b>FEMALE</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>MARCH 14, 1880</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY _____</p>	<p>9. AGE (In years lost birthday) <b>89</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b></p>	
<p>13. FATHER'S NAME <b>Andrew J. Hugg</b></p> <p><del>Andrew Jackson Heng</del></p>		<p>14. MOTHER'S MAIDEN NAME <b>MARY Elizabeth IRWIN</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p>		<p>16. SOCIAL SECURITY NO. <b>217-09-2454D</b></p>	<p>17. INFORMANT <b>Keswick Records</b></p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Arteriosclerotic Cardiovascular Disease</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF: _____</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 yrs</b></p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): _____</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>	<p>20A. AUTOPSY? (Yes or No) _____</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>18 Feb 1965</b> to <b>16 Jan 1970</b>, that (I) (we) lost saw the deceased alive on <b>16 Jan 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Aubrey D. Richardson M.D.</b></p>		<p>23B. DATE SIGNED <b>16 Jan 1970</b></p>	<p>Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson, M.D.</b></p>		<p>23D. ADDRESS <b>700 W. 40th Street, Baltimore, Md. 21211</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>1/19/70</b></p>	<p>24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b></p>	<p>25B. NAME OF REGISTRAR <b>Robert E. ...</b></p>	<p>25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Maryland</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 00628</span>	
BIRTH NO. <span style="font-size: 1.5em;">B-651</span>		70 00628		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Clyde Clarence Brumfield</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">January 17, 1970</span> <span style="font-size: 1.2em;">3:30 P.</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <span style="font-size: 1.1em;">South Baltimore General Hospital</span>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">843</span>		
5. SEX <span style="font-size: 1.1em;">Male</span> 6. RACE <span style="font-size: 1.1em;">Caucasian</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.1em;">1342 Pontiac Avenue</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">Cecil Brumfield</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Wilma Hart</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.1em;">Mrs. Casimira Brumfield</span>	
				ADDRESS <span style="font-size: 1.1em;">Same</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Acute coronary occlusion 1 hour</span> (B) <span style="font-size: 1.2em;">coronary thrombosis</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">coronary artery disease</span> <span style="font-size: 1.2em;">none</span>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 hour</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">1950</span> to <span style="font-size: 1.1em;">Jan. 17</span> 19 <span style="font-size: 1.1em;">70</span> . that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Jan. 17</span> 19 <span style="font-size: 1.1em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Imre Neubauer</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">Jan. 17, 1970</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Imre Neubauer M.D.</span>			23D. ADDRESS <span style="font-size: 1.1em;">936 Patapsco Ave. Baltimore, Md.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">1/21/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Spring Hill Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Huntington West Virginia</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JAN 20 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Leonard O. Buck Inc.</span>	
				ADDRESS <span style="font-size: 1.1em;">5305 Harford Road 21211</span>	

Widow's Affidavit and her Driver's License  
1-26-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00629</u>	
BIRTH NO. <u>10-122</u>		70 00629		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Joseph Novachek</b>			2. DATE AND HOUR OF DEATH <b>January 18, 1970 12:50 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>316 South Folcroft St</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1911</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Frank Novachek</b>			14. MOTHER'S MAIDEN NAME <b>Mary Shane</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12/31 1969</b> to <b>1/17 1970</b> , that (I) <del>was</del> lost saw the deceased alive on <b>1/7 1970</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.					
23A. SIGNATURE <b>Joseph R. Liberto, M.D.</b>			23B. DATE SIGNED <b>1/18/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Joseph R. Liberto M.D.</b>			23D. ADDRESS <b>2110 Old Frederick Rd Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/20/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Trinity</b>	24D. LOCATION (City, town, or county) (State) <b>Nanticoke Penna.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones, R.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		





BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN ERBLAND

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 17, 1970

10:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 17, 1970

10:00 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Cockeysville

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Dec 5, 1928

10. AGE (In years last birthday)

41

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

10106 Charington Road

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Henry O Erbland

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucille M Erbland

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11

17. SOCIAL SECURITY NO.  
115-20-1867

18. INFORMANT

Mrs Barbara M Erbland

ADDRESS

Same

19. E 923.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Conflagration

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
Motel22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

Gaslight Motor Lodge 1034 York Rd. #49

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 1-4-70 3:45 A. m.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Explosion in room threw subject out  
window, 2nd flr. to pavement.

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Tsodore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 18, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/21/70

24C. NAME of CEMETERY or CREMATORY

Holy Sepulchre

24D. LOCATION (City, town, or county)

Rochester New York

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc. Baltimore, Maryland

ADDRESS

ACADEMY FORD

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00631</u>
BIRTH NO. <u>70 00631</u>		1. NAME OF DECEASED (Type or Print) <u>RICHARDSON ROBERT C.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>1-19 1970 11, 17 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>04-14-07</u>		
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEAN</u>		
11. BIRTHPLACE (State or foreign country) <u>NEW HAMPSHIRE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>LEON RICHARDSON</u>		14. MOTHER'S MAIDEN NAME <u>MILLITENT WARNOCK</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>0085 29 7343</u>		
17. CAUSE OF DEATH		18. ADDRESS <u>11 1/2 School St Hanover N.H.</u>		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Long alk. abus and emphysema.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>P.O.H.</u> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-29</u> 19 <u>69</u> to <u>1-19</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>1-19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>G. P. Mikus M.D.</u>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>G. P. MIKUS</u>				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-23-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pine Knolls</u>
24D. LOCATION (City, town, or county) (State) <u>Hanover, Centon, New Hampshire</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Gabe, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. C. Brooks Towson</u>		
25D. ADDRESS <u>1050 York Road Towson Md 21204</u>				

LEON RICHARDSON  
MALE WHITE  
X

NEW HAMPSHIRE  
CP-W-C 52  
JACK IRVING-WAY 52  
X

DEAN  
MICHAEL L. RICHARDSON

LEON RICHARDSON  
52-15-250

252

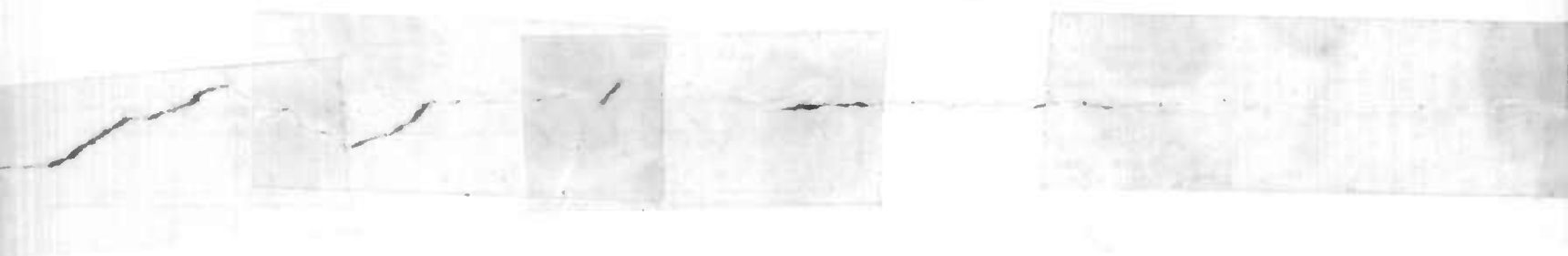
1-15-250

J. D. RICHARDSON  
J. D. RICHARDSON  
X

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
B-352		70 00632		70 00632	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BERNADINE T. BITTINGS		1/16/70		4:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md.		B. COUNTY	
BALTIMORE CITY HOSPITAL		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4940 Eastern Avenue - Baltimore, Md. 21224		E. STREET AND NUMBER 3607 Fait Avenue # 21224.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/16	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Cuzinski		14. MOTHER'S MAIDEN NAME Ann Novbaski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT 4940 Eastern Ave BCH Records- Balto., Md. 21224	
18. 427.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 1 week	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/12/70 to 1/16/70 and that (1) (we) last saw the deceased alive on 1/16/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dale P. Henken, M.D.		23B. DATE SIGNED 1/16/70			
23C. PHYSICIAN'S NAME (Type) Dale P. Henken, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave. Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION 4430 Belair Rd., Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 20 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. DATE REC'D BY HEALTH DEPT. JAN 20 1970		24H. NAME OF REGISTRAR Robert E. Taylor, M.D.		24I. FUNERAL DIRECTOR Charles J. Jailer	
24J. ADDRESS 901 S. Conkling St. Balto., 21224, Md.		24K. ADDRESS 901 S. Conkling St. Balto., 21224, Md.			



many birds

# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>L-000</span> <span>70 00633</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 70 00633</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>LEE, HERBERT H. S.</b>		2. DATE AND HOUR OF DEATH <b>January 16th, 1970</b>   <b>9:15</b> AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Saint Agnes Hospital</b> <b>40 Caton &amp; Wilkens Aves. 21229</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard Co 63-00</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2619 Litter Court 21043</b>	
5. SEX <b>M</b>	6. RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/09</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>Balto City Schools</b>		9. AGE (In years last birthday) <b>60</b>
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Herbert R. Lee</b>		14. MOTHER'S MAIDEN NAME <b>Anna Horchler</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-01-5986</b>	
17. INFORMANT <b>Mrs. Herbert H. Lee Sr.</b>		ADDRESS <b>2619 Litter Court</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>410.9 I Coronary Occlusion</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Artery Disease</b>		(B) DUE TO OR AS A CONSEQUENCE OF: <b>Coronary Artery Disease</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Congestive Heart Failure</b>		(C) DUE TO OR AS A CONSEQUENCE OF: <b>1 month</b>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>1/14/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1953</b> to <b>Jan 16 1970</b> that (I) (we) last saw the deceased alive on <b>1/14/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Herbert H. Lapp</b>		23B. DATE SIGNED <b>1/16/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Herbert Lapp Md</b>		23D. ADDRESS <b>4808 FARMERS AVE. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>1/16/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS UNIVERSITY</b>		24D. LOCATION (City, town, or county) (State) <b>709 N. Wolfe St</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>John E. Lapp</b>	
25C. FUNERAL DIRECTOR <b>WATKINS FUNERAL HOME EDWARDS</b>		ADDRESS	

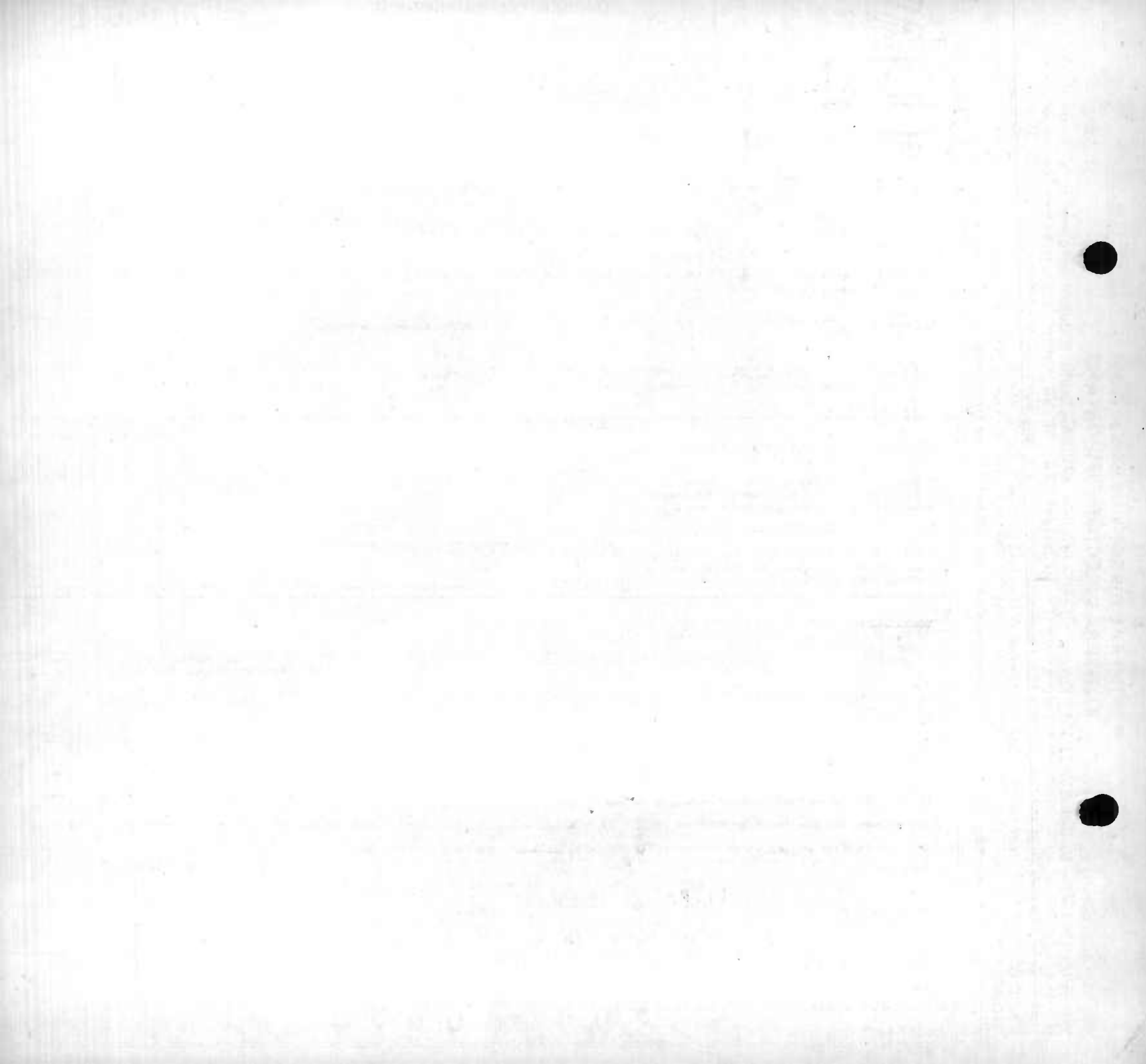
VS 153 1-20-70 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

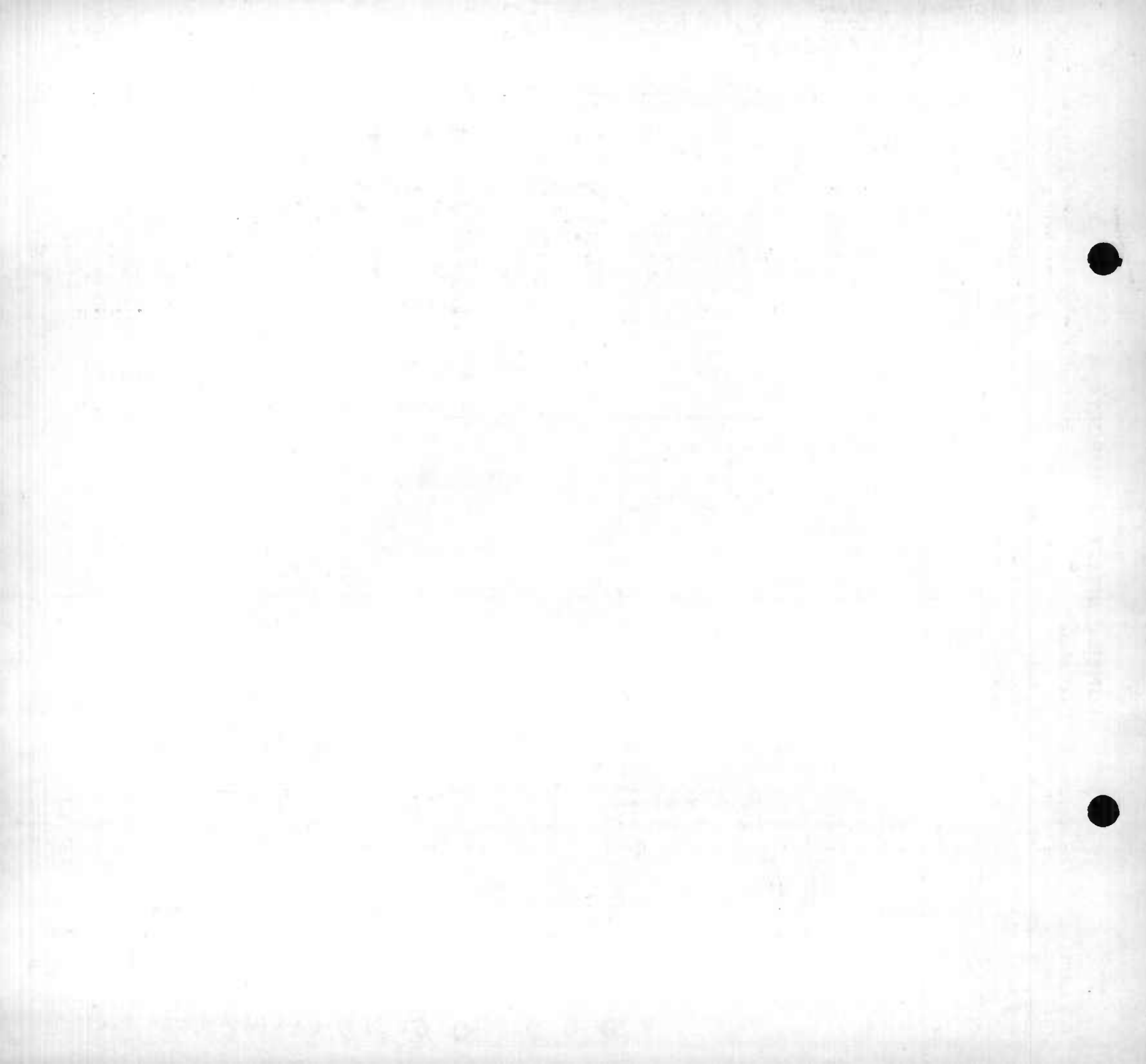
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00634</u>	
B-260 70 00634		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Marian Buecker</u>		2. DATE AND HOUR OF DEATH <u>Jan. 12, 1970</u>   <u>10</u> <u>30</u> <u>a.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1538</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>KENESAW NURSING HOME</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2601 ROSLYN AVE.</u>					
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>90</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>unk</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>KENESAW - N. H</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>431.91</u> <u>Cerebral hemorrhage</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <u>12/20</u> 19 <u>62</u> to <u>1/12</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <u>Robert A. Reiter M.D.</u>				23B. DATE SIGNED <u>1/12/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>				23D. ADDRESS <u>606 Edmondson Ave 21228</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>1/16/70</u>		24B. DATE <u>1/16/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MED. SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u>			
25B. NAME OF REGISTRAR <u>000000</u>		25C. FUNERAL DIRECTOR <u>REITER FUNERAL HOME BALTO., Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

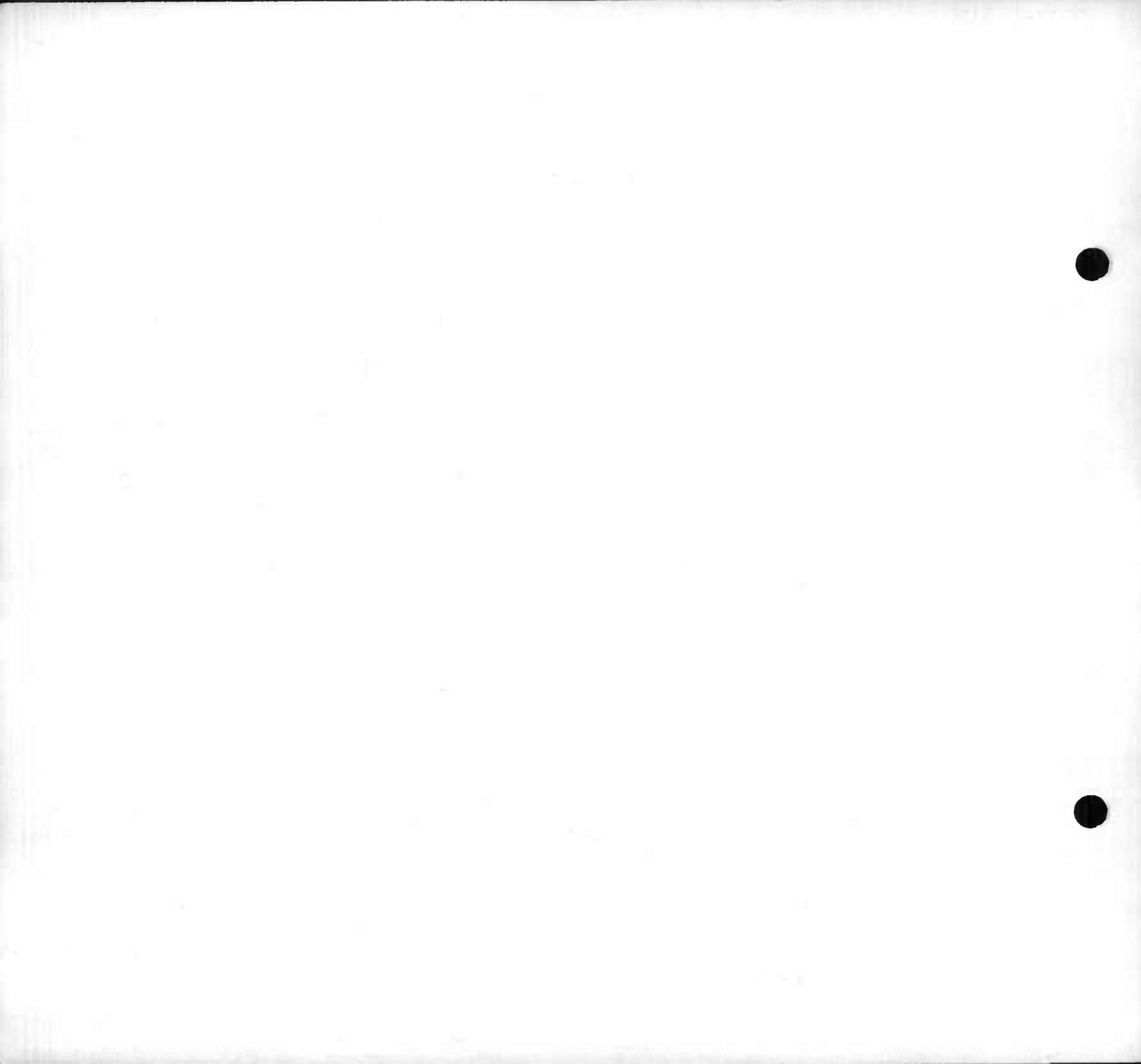
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00635 4	
B-346 70 00635 BIRTH NO. 70-00492		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Girl Butler Deborah		2. DATE AND HOUR OF DEATH 1.10.70 11.59 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 907			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 21224 4940 Eastern Avenue Baltimore, Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1.10.70		9. AGE (in years last birthday) 11		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mins: 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Spellman		14. MOTHER'S MAIDEN NAME Deborah Butler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224	
18. 777 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes) or No Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-10 19 70 to 1-10 19 70, that (I) (we) lost saw the deceased alive on 1-10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Liongo Siang Kho		23B. DATE SIGNED 1/11/70		23C. PHYSICIAN'S NAME (Type) LIONGO SIANG KHO KHO	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1-12-70		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		24E. ADDRESS 4940 Eastern Avenue Baltimore, Maryland		24F. FUNERAL DIRECTOR HOSPITAL DISPOSAL	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1970		25B. NAME OF REGISTRAR		25C. ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>70-60 491</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70 00636</u>	
1. NAME OF DECEASED (Type or Print) <u>Wilson Baby Boy, Deborah</u>			2. DATE AND HOUR OF DEATH <u>1-11-70</u> <u>1:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2002</u>		
5. SEX <u>Male</u>			6. RACE <u>Negro</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-11-70</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>Deborah Wilson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>BCH: Records Baltimore, Maryland 21224</u>			ADDRESS <u>4940 Eastern Avenue</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2 NONE</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>2:30 AM 1/11 19 70</u> to <u>1:30 PM 1/11 19 70</u> that (I) (we) last saw the deceased alive on <u>1/11 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Richard M. Trailer MD</u> 23B. DATE SIGNED <u>1/12/70</u> 23C. PHYSICIAN'S NAME (Type) <u>RICHARD M. TRAILER MD</u> 23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland</u> <u>BALTIMORE CITY HOSPITAL, Md 21224</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> 24B. DATE <u>1-12-70</u> 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CITY HOSPITALS</u> 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND 21224</u> 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u> 25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u> ADDRESS					



N 854.0 1 1 0 0

address is 2703 Presbury St.  
Telephone directory.



Buchanan, George  
118 N 75

## FUNERAL DIRECTOR: IMPORTANT

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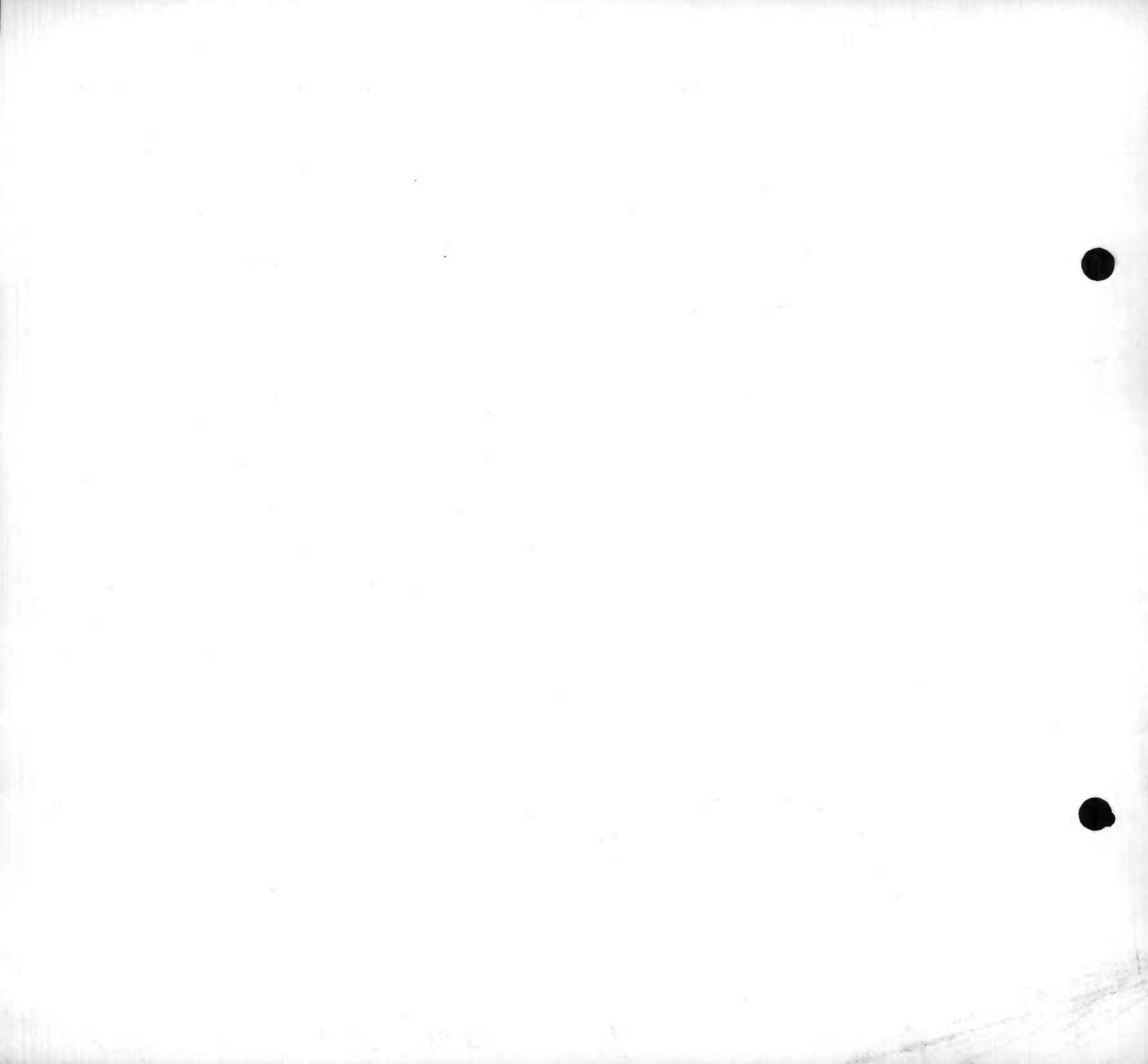
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00638	
BIRTH NO. B-255		70 00638		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <b>GEORGE BUCHANAN</b>		2. DATE AND HOUR OF DEATH <b>JAN 16, 1970 6:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>1001</b>	
ADDRESS OR LOCATION <b>BALTIMORE, MD 21205</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>915 E. CHASE STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>05-07-04</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SC</b>	
13. FATHER'S NAME <b>SAM</b>		14. MOTHER'S MAIDEN NAME <b>LETTIE Brown</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>250-20-7019</b>		17. INFORMANT <b>Louise Scott 837 11th Court</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>796.04 I 303.9</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. <b>II</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>RESP. ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <b>ALCOHOLISM, SEIZURES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/16/70</b> to <b>1/17/70</b> that (I) (we) last saw the deceased alive on <b>1/16/70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Bensinger MD</b>				23B. DATE SIGNED <b>Jan 16, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD BENINGER MD</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan 21/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>McAuburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Westport, md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Chas E. Jones</b>		25C. FUNERAL DIRECTOR <b>Charles E. Johnson 1129 N. Carbon St</b>	



# FUNERAL DIRECTOR: IMPORTANT

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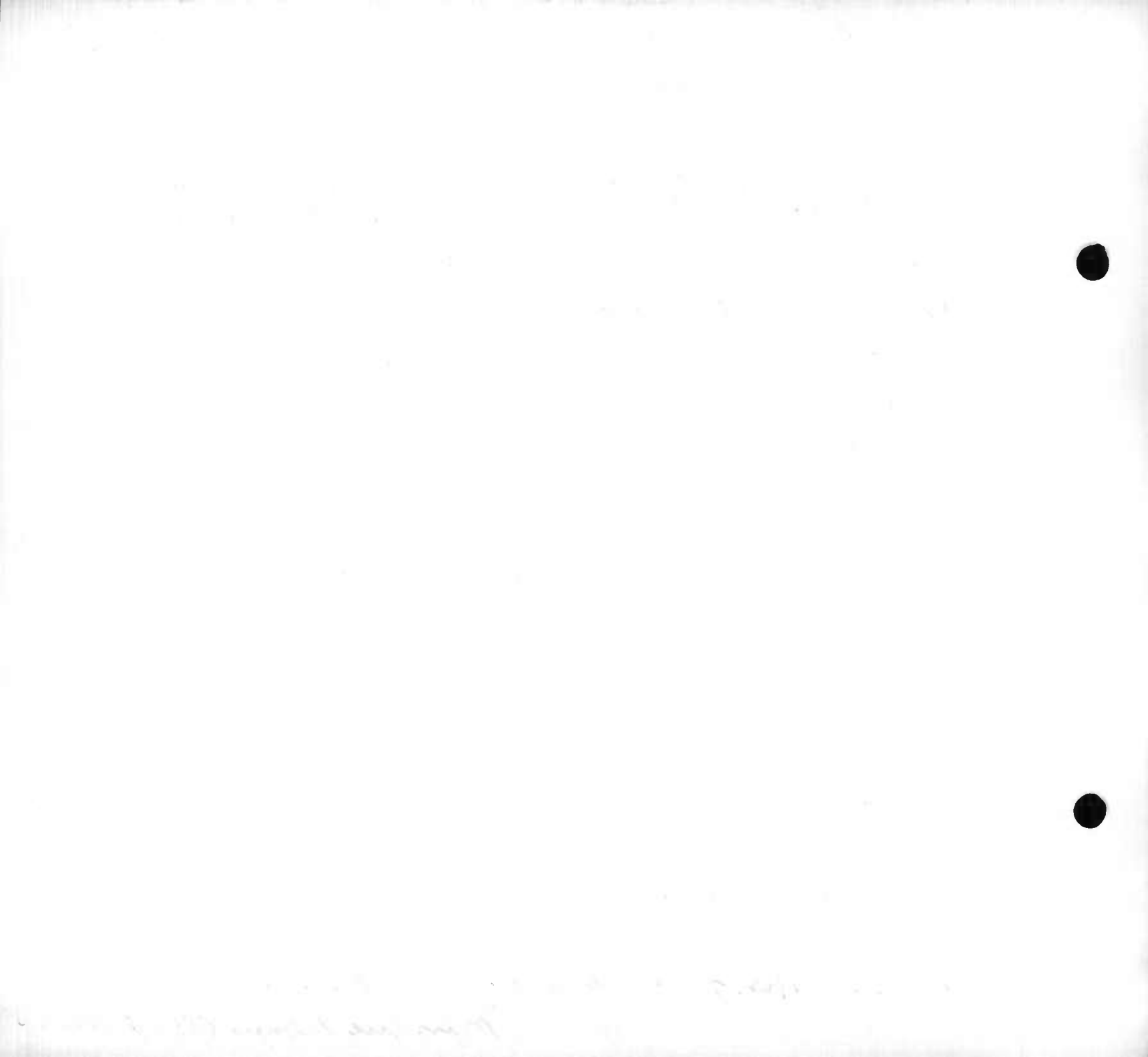
<div style="display: flex; justify-content: space-between;"> <span><b>R-152</b></span> <span><b>70 00639</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO.</b> <b>70 00639</b>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HENRY ROBINSON</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>Jan. 18, 1970 5:40 A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) <b>A. STATE &amp; COUNTY</b> <b>MARYLAND, USA 807</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>1627 E. FEDERAL ST.</b>			
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>N</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/25/04</b>	<b>9. AGE</b> (In years last birthday) <b>65</b>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Oil Burner Operator</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Boston Hotel Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>VIRGINIA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Jim Robinson</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>not known</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (If yes, give war or dates of service) <b>none.</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>220-12-8591</b>		<b>17. INFORMANT</b> <b>Ada Robinson (wife)</b> <b>ADDRESS</b> <b>1627 E. Federal St. MD.</b>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>491X I</b>		<b>CAUSE OF DEATH</b> <b>Acute Respiratory</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>unk.</b>	
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		<b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Failure + electrolyte imbalance</b>		<b>unk.</b>	
<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Emphysema</b>		<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Chronic Bronchitis</b>		<b>unk.</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>can pulmonary &amp; congestive heart failure</b>			
<b>19A. DATE OF OPERATION</b> <b>1/15/70</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Respiratory distress</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (he/she) attended the deceased from Jan. 12 1970 to Jan. 18 1970 that (he/we) last saw the deceased alive on Jan. 18 1970 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did/did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Rolando A. Mendoza</b>		<b>23B. DATE SIGNED</b> <b>1/18/70</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>ROLANDO A. MENDOZA, M.D.</b>	
<b>23D. ADDRESS</b> <b>100 N. BROADWAY ST. BALTO. MD. 21231</b>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>24B. DATE</b> <b>Jan 22/70</b> <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Carver Memorial</b> <b>24D. LOCATION</b> <b>Lanham, Md</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 20 1970</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, Jr.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Elbert J. General Home</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-636 70 00640		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00640	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUISE PERSON CARTER		JAN 19, 1970 10:30 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND 1901	
33 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		237 N. GILMORE STREET	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months: Days: Hours: Min.
NEGRO FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/24/02	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BEAUTICIAN		SELF EMPLOYED		ROCK HILL S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HENRY MC NEIL		RENA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218 07 4134		MEVA LEE BRANCH EAST ORANGE N.J.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 HRS	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 HRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		(C) METASTATIC ABDOMINAL CA. ASCITES ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		PRIMARY UNCERTAIN			
AORTIC STENOSIS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from		JAN 17 1970 to		JAN 19, 1970	
that (1) (we) last saw the deceased alive on		JAN 19, 1970		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Nicholas A. Veljicelli MD		JAN 19, 1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/22/70		MT AUBURN	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1970		E. J. J. J.		James Earl R. Hughes 638 N. GILMORE ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
M-245 70 00641				70 00641	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>McCollum, Joseph</b>				1/18/70 at 9:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>				A. STATE <b>MARYLAND</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>2788</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3338 W. BELVEDERE AVENUE</b>	
5. SEX <b>M</b>	6. RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/47</b>	9. AGE (In years last birthday) <b>22 1/2</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			11. BIRTHPLACE (State or foreign country) <b>DILLON S.C.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>GURLEY McCollum</b>			14. MOTHER'S MAIDEN NAME <b>GENEVA McCollum</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <b>759.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-RESPIRATORY ARREST.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>UREMIA (RENAL FAILURE)</b>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>MONGOLOID</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>70</b> to <b>1/18</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kapoor 9088 M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. NEELAM KAPOOR</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>1/20/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR <b>[illegible]</b>	
				ADDRESS <b>638 N. GILMAN ST</b>	

[REDACTED]



*Faint, illegible handwriting at the bottom of the page.*



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
B-453		70 00642		70 00642	
1. NAME OF DECEASED (Type or Print) <b>JOSA BLANDFORD</b>			2. DATE AND HOUR OF DEATH <b>JAN 16 1970 8<sup>45</sup> A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b> <b>38</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1601</b>		
5. SEX <b>F</b>			6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>NOV 4 1946</b>			9. AGE (In years last birthday) <b>23</b>		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>THOMAS BLANDFORD</b>		
14. MOTHER'S MAIDEN NAME <b>ISADORA DORSEY</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Isadora Blandford</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Viral Hepatitis</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 13 1970</b> to <b>Jan 16 1970</b> that (I) (we) last saw the deceased alive on <b>Jan 16 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald S. Pototsky M.D.</b>			23B. DATE SIGNED <b>Jan 16, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>RONALD S. POTOTSKY, M.D.</b>
23D. ADDRESS <b>UNIVERSITY HOSP. BALTO MD 21207</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/21/70</b>			24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		
24D. LOCATION (City, town, or county) (State) <b>Balto. City</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		
25B. NAME OF REGISTRAR <b>RECEIVED</b>			25C. FUNERAL DIRECTOR <b>of Brown Sons M.S.</b>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00643</u>	
BIRTH NO. <u>5-3-72</u> <u>70 00643</u>		CERTIFICATE AMENDED	
1. NAME OF DECEASED (Type or Print) <u>Ruth C. Tipton</u>		2. DATE AND HOUR OF DEATH <u>6 Jan 70 10829 A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1203</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2529 Guilford Ave</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>06-14-10</u>		9. AGE (in years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Cobee</u>		14. MOTHER'S MAIDEN NAME <u>Carrie P. Flashell</u> <u>Catherine Peisell</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		ADDRESS	
18. <u>199.0 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <u>D.H.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-01 1969</u> to <u>1-6 1970</u> that (I) (we) last saw the deceased alive on <u>1-6 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>M. Condon M.D.</u>		23B. DATE SIGNED <u>6 Jan 70</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY		24D. LOCATION (town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fickel, M.D.</u>	
25C. FUNERAL DIRECTOR		ADDRESS	



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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00644

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HARRY A. ADDISON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>517 Wyeth St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 18 70 4 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>9-15-06</b>		10. AGE (In years lost birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Addison</b>		14. MOTHER'S MAIDEN NAME <b>Georgeanna</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive &amp; Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-19-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

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WATERBURY

WATERBURY

WATERBURY

1884

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P-626

70 00645

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00645

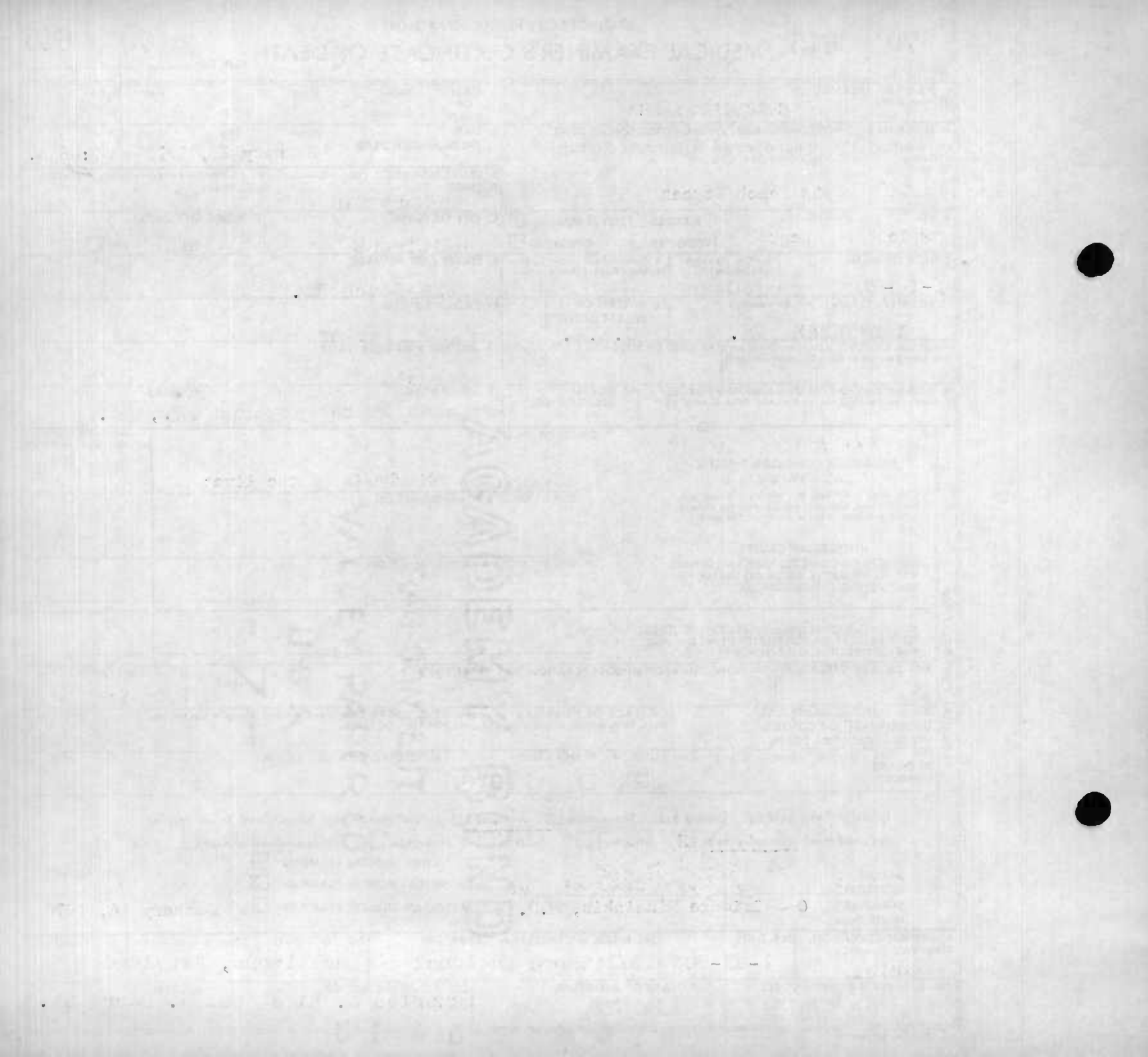
BIRTH NC.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES A. PARKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 16, 1970 9:06 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 928 Peach Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 16, 1970 9:06 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-18-20		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Parker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Md.	
15. MOTHER'S MAIDEN NAME Georgia		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Frances White Severna Pk., Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-70	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

70 00645







1  
C-455

70 00646

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00646

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM E. COLEMAN

2. DATE,  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

January 14, 1970

5:18 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 14, 1970

5:18 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1402

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1 May 1890

10. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months; Days; Hours; Min.

E. STREET AND NUMBER

520 Mc Mechen

11. BIRTHPLACE (State or foreign country)

Alexandria, Va.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Unknown

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Julia

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

17. SOCIAL  
SECURITY NO.

218-10-3054A

18. INFORMANT

ADDRESS

Mrs. Etta Coleman - 520 Mc Mechen

19.

412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 15, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

19 JAN 1970

24C. NAME OF CEMETERY or CREMATORY

BALTIMORE NAT'L

24D. LOCATION (City, town, or county)

BALTIMORE, MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 20 1970

25B. NAME OF REGISTRAR

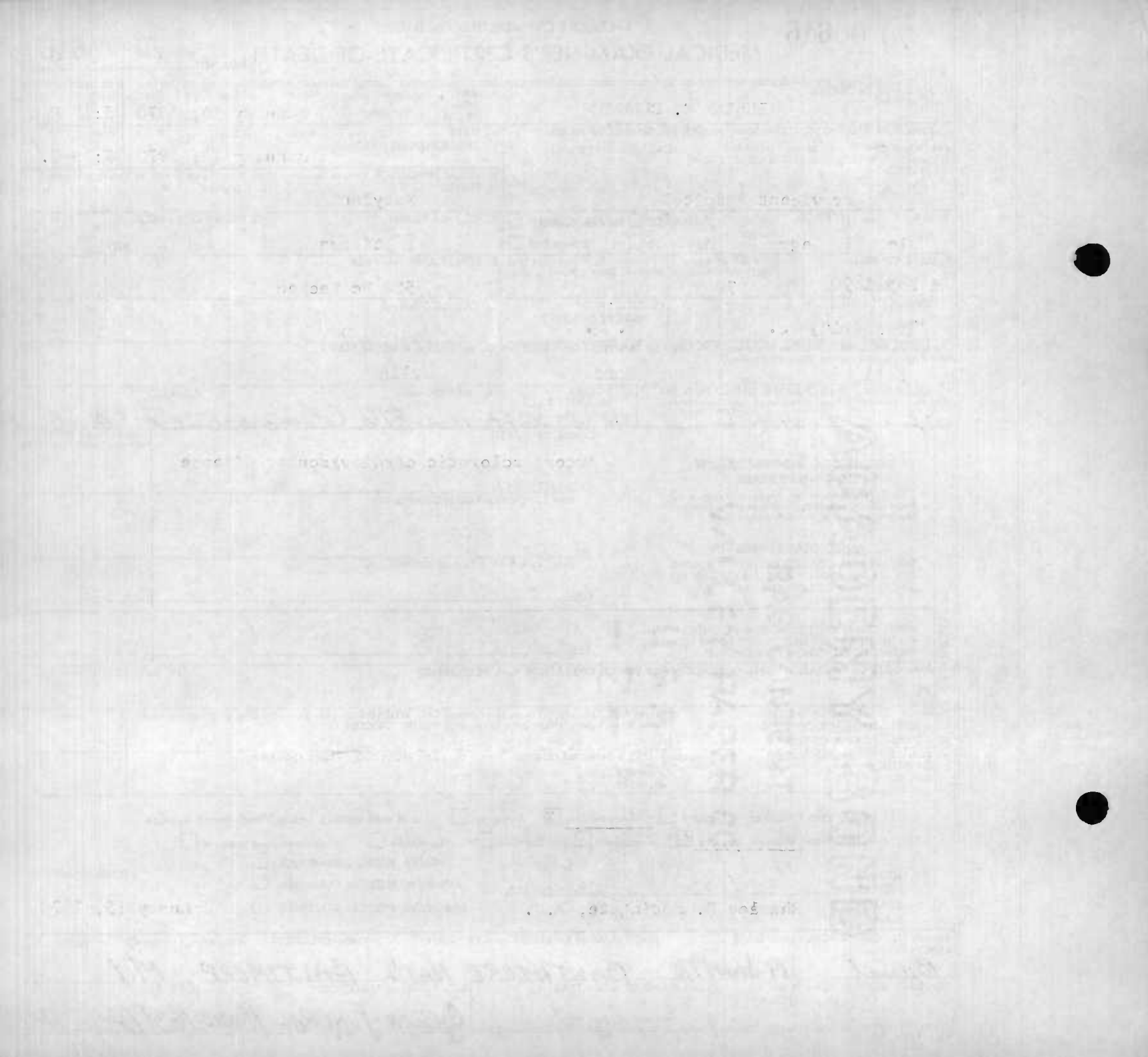
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

GIBSON FUNERAL HOME - 1631 DRUID HILL

ADDRESS

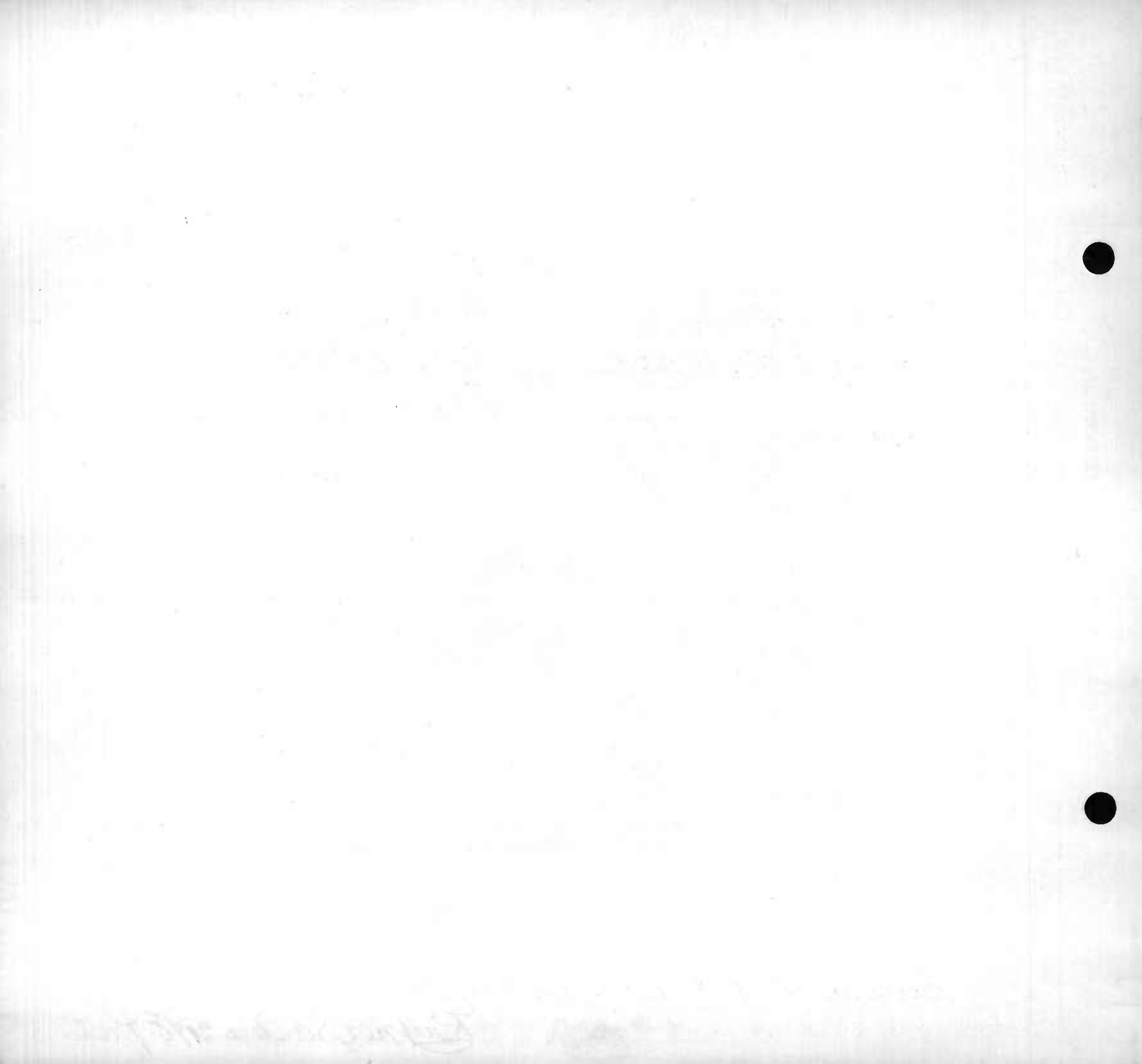
AYE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00647		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00647	
1. NAME OF DECEASED (Type or Print) <b>MADALENE SANDERS</b>			2. DATE AND HOUR OF DEATH <b>1/15/70 4:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>909</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8-26-1905</b>		9. AGE (In years last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Harry Hayward</b>			14. MOTHER'S MAIDEN NAME <b>Susie Patterson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edgar Sanders</b>
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intracerebral Hemorrhage</b> (B) <b>HASCD</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1/14 1970</b> to <b>1/15 1970</b> , that (I) (we) lost saw the deceased alive on <b>1/15 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Z. Sagan, M.D.</b>			23B. DATE SIGNED <b>1/15/70</b>		23C. PHYSICIAN'S NAME (Type) <b>SANDRA Z. SAGAN M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>1-19-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cem</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Raymond Sanders</b>
24D. LOCATION (City, town, or county) <b>A.A. Co</b>			24E. ADDRESS <b>University of Md Hospital</b>		
24F. ADDRESS <b>217 E. Preston St</b>			24G. ADDRESS <b>217 E. Preston St</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00648</u>	
BIRTH NO. <u>70 00648</u>		CERTIFICATE OF DEATH <span style="float: right;">X</span>			
1. NAME OF DECEASED (Type or Print) <u>RUSSELL E OWENS</u>		2. DATE AND HOUR OF DEATH <u>1/18/70</u> <u>3<sup>25</sup></u> <u>P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>VA.</u> B. COUNTY <u>FREDERICK</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSP.</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>STEPHENSON</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>RFD #1</u>	
5. SEX <u>M</u>	6. RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/13</u>	9. AGE (In years last birthday) <u>56</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>CHARLES LEWIS RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>PAINTER, JESSIE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>230-24-1507</u>		17. INFORMANT <u>LILLIAN W. OWENS</u> ADDRESS <u>STEPHENSON VA.</u>	
18. <u>410.9 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL EDEMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HRS</u>	
		(B) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>AS IT IS</u>		<u>HRS → DAYS</u>	
		(C) <u>DIABETES MELLITUS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/18/70</u> to <u>1/18/70</u> and that (I) (we) saw the deceased alive on <u>1/18/70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>U. Susan Dellingjer MD</u>		23B. DATE SIGNED <u>1/18/70</u>		23C. PHYSICIAN'S NAME (Type) <u>U. Susan Dellingjer MD</u>	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-19-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>SHENANDOAH MEMORIAL PARK</u>	
24D. LOCATION <u>Winchester, Frederick, VA.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Elmer E. Talley, M.D.</u>	

2011

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
C-100		70 00649		70 00649	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Viola CUFF		Jan 16, 1970		11:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
B.C.H. Baltimore City Hospital		Maryland		1601	
4940 Eastern Ave. Balto., Md. 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
31		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
8-28-1913		56		11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Jabb		Ella M.N. Unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				BCH Records 4940 Eastern Avenue Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
250.9 I		ASCVD		Long standing	
I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Aug 1968	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Long standing	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Alcoholism - Diabetes Mellitus			
II		SY.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-2-1968 to 1-16-1970 that (I) (we) last saw the deceased alive on 1-16-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. Mutlu Atagun		1-16-1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Mutlu Atagun M.D.		BCH Baltimore City Hospital 4940 Eastern Ave. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/20/70		Baltimore National	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1970		J. J. J. J.		W. J. J. J.	
				ADDRESS	
				1727 N. Meade St.	

~~XXXXXXXXXX~~  
Called City Hospitals, last address  
was 1125 N. Jackson St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

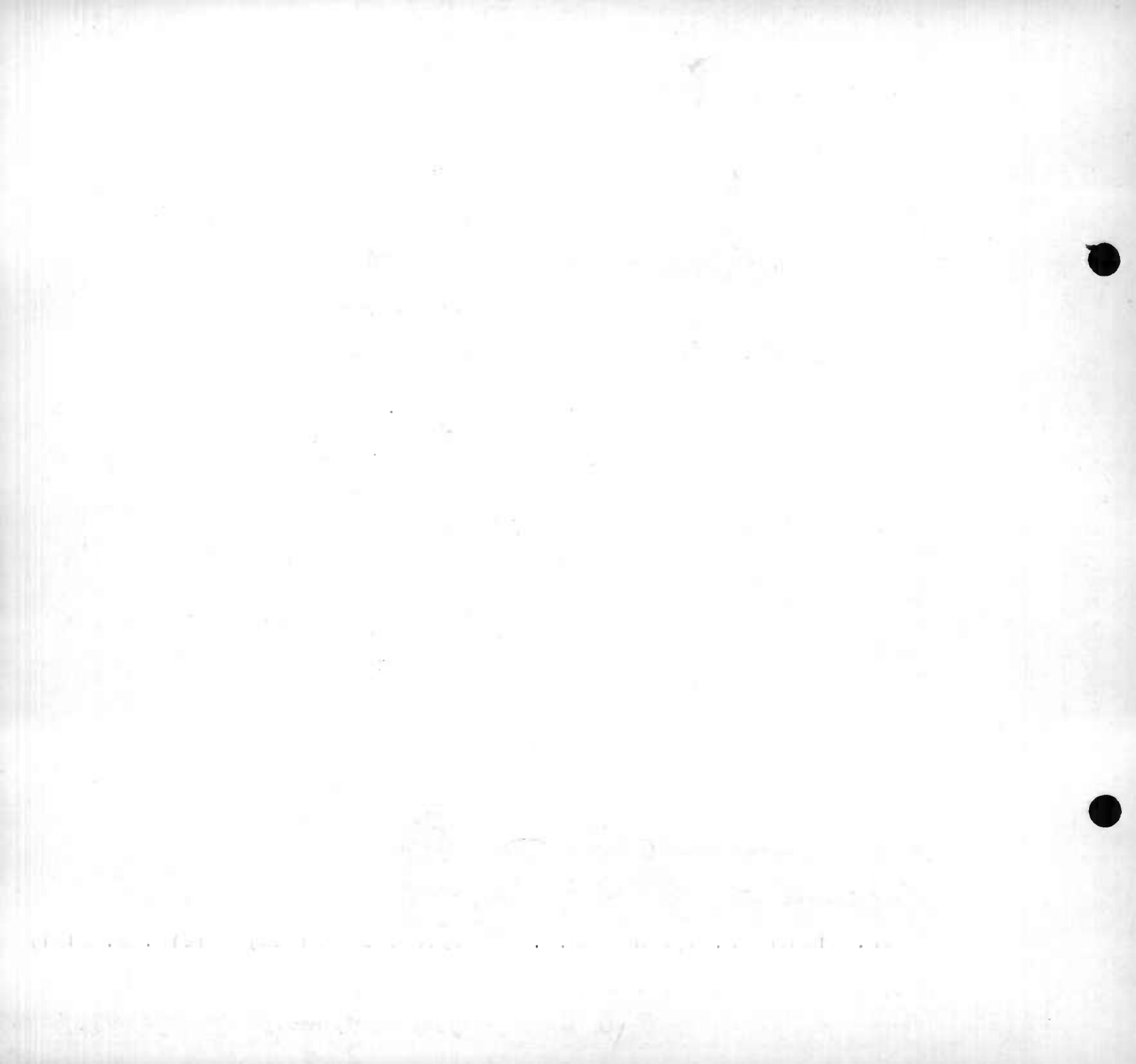
BIRTH NO. <b>H-536</b>		70 00850		CERTIFICATE OF DEATH		REG. NO. <b>70 00850</b>	
1. NAME OF DECEASED (Type or Print) <b>Thurman N. Henderson</b>				2. DATE AND HOUR OF DEATH <b>1/18/70</b> <b>7:20</b> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>406 East 21st Street</b>		<b>21218</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-24-27</b>	9. AGE (In years last birthday) <b>42</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Russell Henderson</b>				14. MOTHER'S MAIDEN NAME <b>Octavia Thomas</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W.W. II</b>				16. SOCIAL SECURITY NO. <b>229-22-1389</b>		17. INFORMANT ADDRESS <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Arrest</b> <b>Ca of Larynx</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-8-</b> <b>19 70</b> to <b>1-18</b> <b>19 70</b> , that (I) (we) last saw the deceased alive on <b>1-18</b> <b>19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Wisneski M.D.</b>				23B. DATE SIGNED <b>1-18-70</b>		23C. PHYSICIAN'S NAME (Type) <b>J. WISNESKI M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Henderson family plot</b>		24D. LOCATION (City, town, or county) (State) <b>Handover Co. U.A.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Barney General Home</b>		ADDRESS <b>Virginia</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00651</u>	
<div style="display: flex; justify-content: space-between;"> <span>7-520 70 00651</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO. <u>7-520 70 00651</u>					
1. NAME OF DECEASED (Type or Print) <u>Thomas Lee</u>			2. DATE AND HOUR OF DEATH <u>1-17-1970</u> <u>5:45 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nurs. Home</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>2765</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2101 W Coldspring AVE.</u>		
5. SEX <u>MALE</u>	6. RACE <u>Nonwhite</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1896</u>	9. AGE (In years) last birthday <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA. U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN Bill Thomas</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Love A. Elliott</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>218-05-4091</u>		17. INFORMANT ADDRESS <u>CHART # 845 607 PENNAVE</u>	
18. <u>412.2.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>GENERALIZED ARTERIOSCLEROSIS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HASCVI</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>GANGRENE LEFT FOOT 4 WKS.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>10 MAY 1969</u> to <u>17 JAN 1970</u> , that (2) (we) last saw the deceased alive on <u>16 JAN 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard F. Tyson, M.D.</u> DEGREE				23B. DATE SIGNED <u>1-17-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard F. Tyson M.D.</u> DEGREE				23D. ADDRESS <u>2320 Eutaw Place, Baltio.Md. 21217</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/21/70</u>		24C. NAME of CEMETERY or CREMATORY <u>174 Calvary Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1970</u>			
25B. NAME OF REGISTRAR <u>0000</u>		25C. FUNERAL DIRECTOR ADDRESS <u>0416 01 MARCH 928 E. NORTH AVE</u>			



70 00652 ME

70-00652

REG. NO.

VS 151-REV. 7/1/6B

SP-100

UNITED STATES DEPARTMENT OF JUSTICE

1964

MEMORANDUM

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT :

RE : [illegible]

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

ALCOHOLIC BEVERAGES TAX

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-4301

BALTIMORE CITY HEALTH DEPARTMENT									
70 00653					CERTIFICATE OF DEATH		REG. NO. 70 00653		
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Sylvia Holt</i>					Jan. 17 1970 3:05 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital 33rd and Calvert Sts.</i>					A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE COUNTY</i>				
					C. CITY OR TOWN <i>Lutherville</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <i>College Manor</i>		53-00		
5. SEX <i>F</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-16-1897</i>	9. AGE (In years last birthday) <i>73</i>	11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <i>Mr. Henry Holt</i>					14. MOTHER'S MAIDEN NAME <i>Mrs. Taborn</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>064-76-444</i>		17. INFORMANT ADDRESS <i>UNION MEMO HOSPITAL RECORDS</i>			
18. <i>427.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <i>Cardio-Resp. arrest</i> DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>12-28-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestinal obstruction</i>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 28</i> 19 <i>69</i> to <i>Jan 17</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>Jan. 17</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>R. C. ...</i>					23B. DATE SIGNED <i>Jan. 17, 1970</i>			23C. PHYSICIAN'S NAME (Type) <i>R. C. ...</i>	
23D. ADDRESS <i>...</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>1-19-1970</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT</i>		24D. LOCATION (City, town or county) (State) <i>BALTIMORE, MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1970</i>		25B. NAME OF REGISTRAR <i>R. C. ...</i>		25C. FUNERAL DIRECTOR <i>...</i>		25D. ADDRESS <i>...</i>			

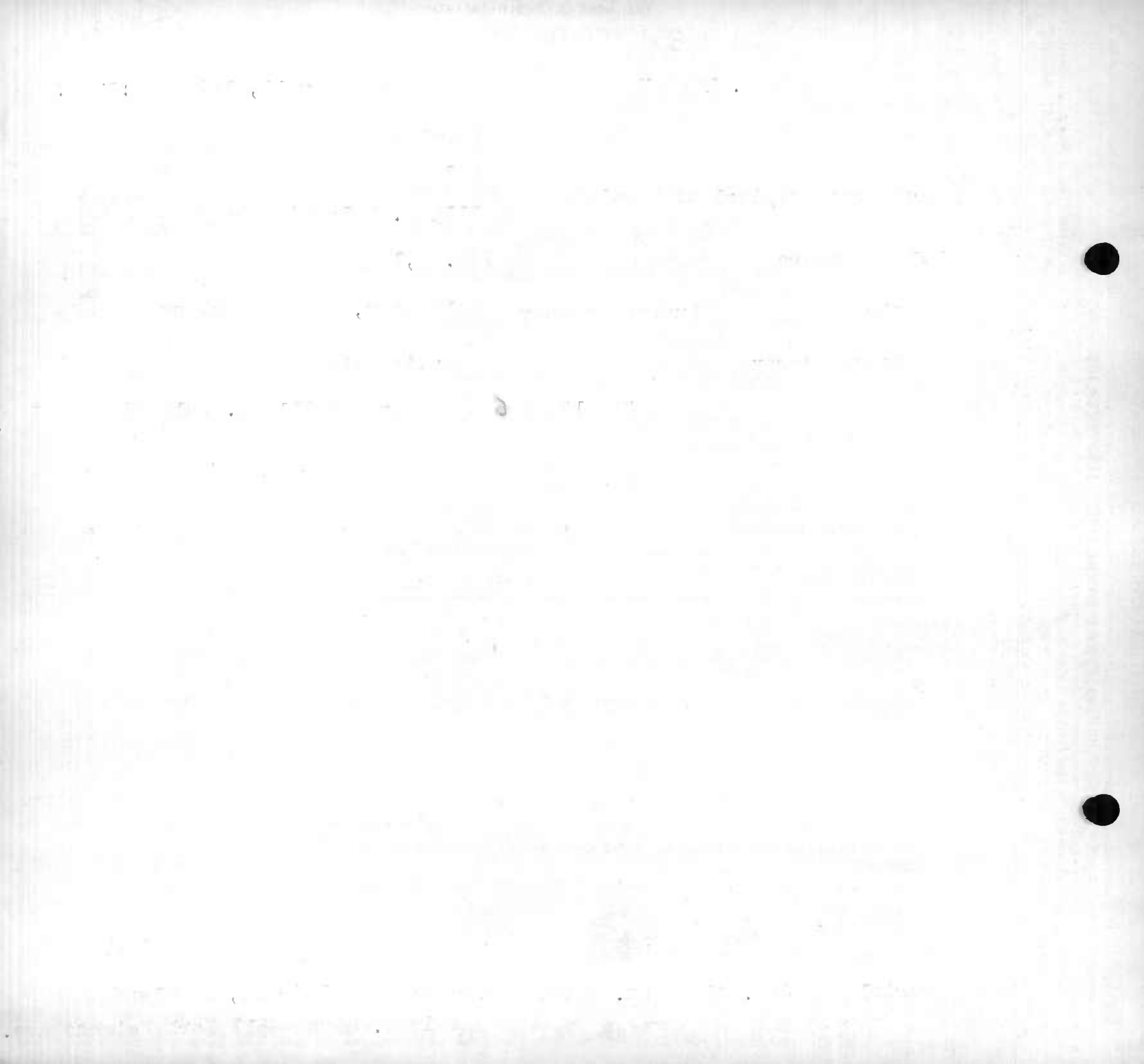




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

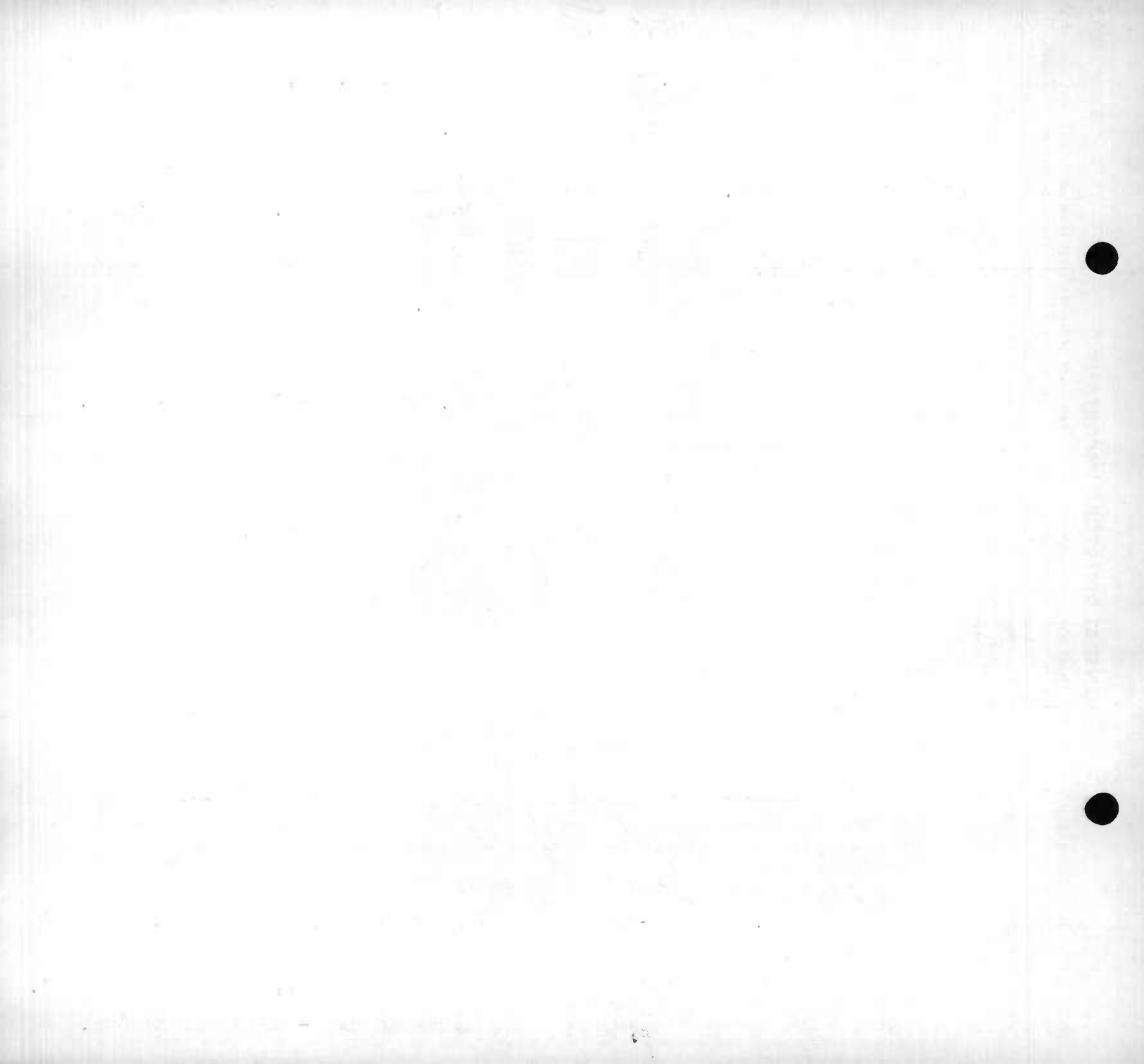
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00654</u>
BIRTH NO. <u>70 00654</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>FRANK E. MURRAY</b>		2. DATE AND HOUR OF DEATH <b>January 19, 1970   9:30 P.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>2115 N. Pulaski Street 1504</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1885</b>	9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lumber Company</b>		11. BIRTHPLACE (State or foreign country) <b>Goldsboro, North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Bunion Murray</b>		
14. MOTHER'S MAIDEN NAME <b>Katie ???</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>240 12 6506 A</b>		17. INFORMANT <b>Ruby Lee 2115 N. Pulaski Street</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9+1 185X</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Coronary Occlusion-Acute</b> <b>1 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hypertensive Card-vasc. Disease</b> <b>Unknown</b>		
		(C) <b>Peripheral Vascular Disease</b> <b>Unknown</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Ca of Prostate Metastases</b> <b>Unknown</b>		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>69</b> to <b>1/15</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>E. E. Holt M.D.</b>		23B. DATE SIGNED <b>1/20/70</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>E. E. Holt, M.D.</b>		23D. ADDRESS <b>3715 Liberty Heights Ave., Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Jan. 23</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>	25C. FUNERAL DIRECTOR <b>Lewis T. Gwynn 4517 Park Heights Ave.</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00655	
<div style="display: flex; justify-content: space-between;"> <span>70 00655</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Nellie M. Nash		Jan. 17, 1970 9 <sup>30</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Md.		
3643 Malden Ave.			8. COUNTY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3643 Malden Ave. 1338		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/29/1892	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Hannon			Anna Miller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Anna Hood - 3643 Malden Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
153.8 I		Carcinoma of colon metastatic to liver		1 year	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 21 1967 to Jan 17 1970, that (I) (we) last saw the deceased alive on Jan 17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
MANUEL LEVIN		1/19/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		6101 PARK HILLS AVE. BALTO -15 MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/20/70		Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 21 1970		Robert E. Taylor, M.D.		Ann Donovan - 3818 Roland Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

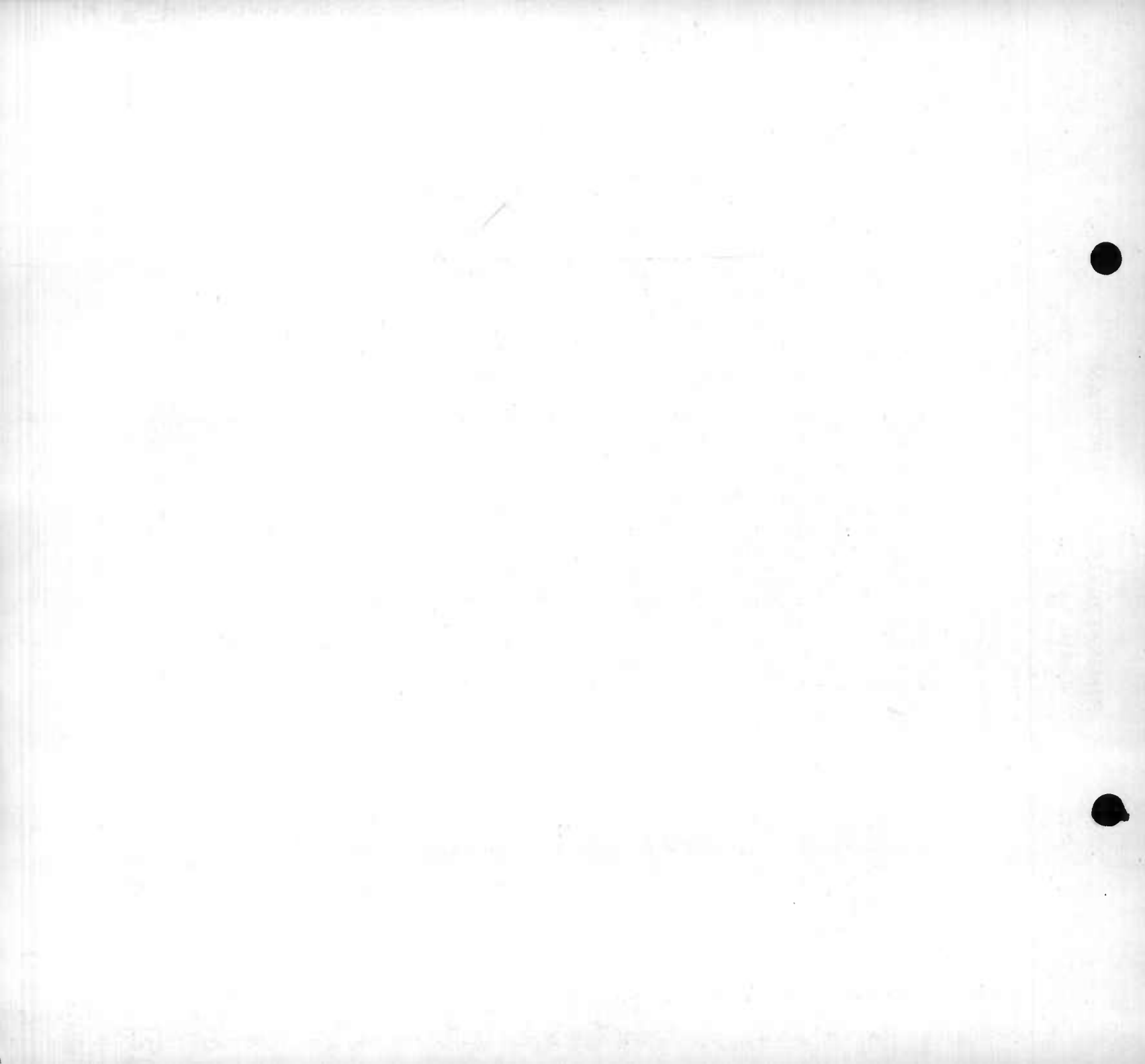
70 00656 CERTIFICATE OF DEATH				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.				REG. NO. 70 00656	
1. NAME OF DECEASED (Type or Print) <b>Richard J. Brewer</b>			2. DATE AND HOUR OF DEATH <b>Jan. 17, 1970</b>   <b>8:30</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3555 Sweet Air St.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3555 Sweet Air St.</b> <b>1348</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1910</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Segal Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Emory Brewer</b>		
14. MOTHER'S MAIDEN NAME <b>Anne Fare</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		
16. SOCIAL SECURITY NO. <b>242-05-0834</b>			17. INFORMANT ADDRESS <b>Margaret Brewer-3555 Sweet Air St.</b>		
18. CAUSE OF DEATH <b>492 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>severe osteoarthritis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>severe osteoarthritis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several yrs.</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>severe osteoarthritis</b>			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several yrs.</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b># @ 3-29 1962</b> to <b>1-17-70</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>Jan 15</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook</b>			23B. DATE SIGNED <b>1-19-70</b>		23C. PHYSICIAN'S NAME (Type) <b>E. BILSWORTH COOK M.D.</b>
23D. ADDRESS <b>2431 Maryland Ave. Balto Md. 21218</b>			24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/21/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>John Donovan</b>		25C. FUNERAL DIRECTOR ADDRESS <b>-3818 Roland Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00657		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00657	
1. NAME OF DECEASED (Type or Print) WALTER ZUREK			2. DATE AND HOUR OF DEATH 1/14/70 6:10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GEN. HOSP 49			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE			6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY BOSTON METAL COMPANY		9. AGE (In years last birthday) 67
13. FATHER'S NAME MICHAEL ZUREK			14. MOTHER'S MAIDEN NAME DOROTHY KUBIAK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-10-3558A		17. INFORMANT MRS. MARY ZUREK
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH Heart MYOCARDIAL INFARCTION DAYS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC HEART DISEASE with (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19. DATE OF OPERATION 0		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank V. Petrino			23B. DATE SIGNED 1/14/70		23C. PHYSICIAN'S NAME (Type) GRACIO V. PATRICIO
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 1/17/70		24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1970			25B. NAME OF REGISTRAR RAYMOND L. KACZOROWSKI		25C. FUNERAL DIRECTOR ADDRESS 2525





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70 00658

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00658

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HELEN LEE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2709 Greenmount Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1970 11:59 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6/11/1925</b>		10. AGE (In years lost birthday) <b>44</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Hawkins Mortuary</b>		ADDRESS <b>Lenoir City, Tenn.</b>	
19. <b>577.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Acute hemorrhagic pancreatitis with gastro-intestinal and retroperitoneal hemorrhage</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/14/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 17, 1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Providence Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Lenoir Loudon county, Tenn.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor M.D.</b>	
25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>		ADDRESS <b>2525 Fleet St. Baltimore, Maryland</b>	

Letter from M.E.'s office

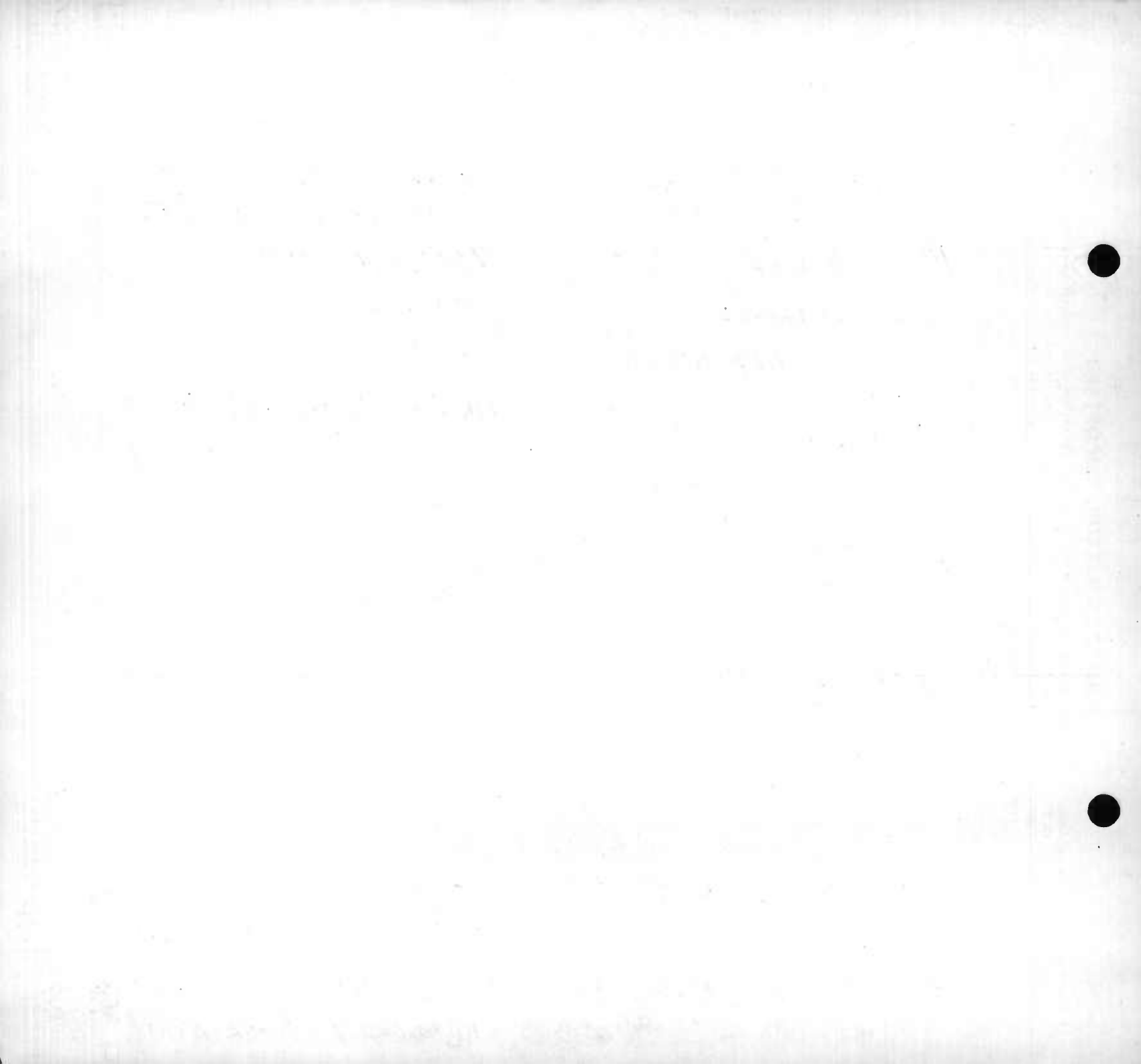
2-3-70

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

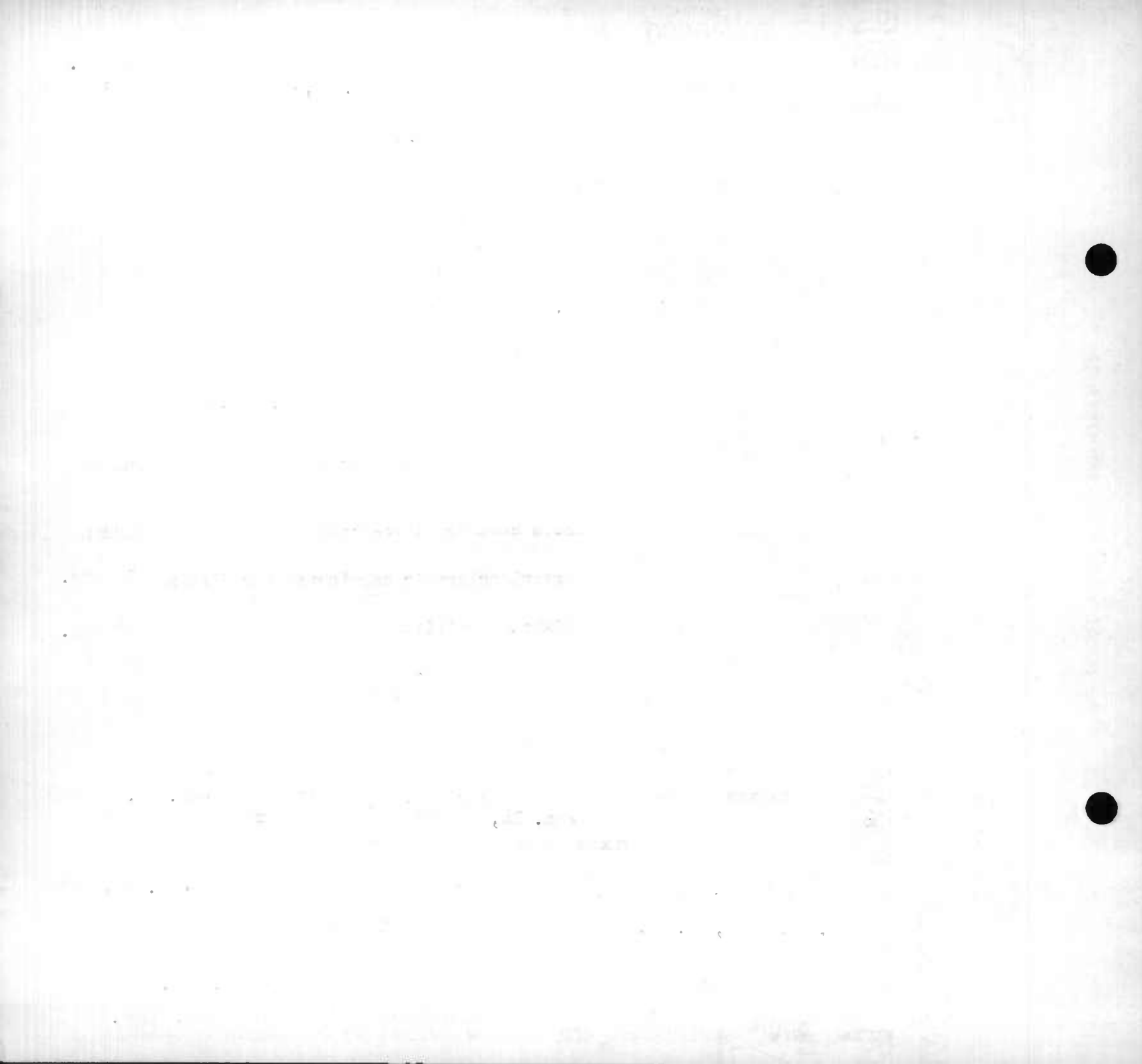
BIRTH NO. 70 00659		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00659	
1. NAME OF DECEASED (Type or Print) <b>JOHN F. BENTKOWSKI</b>			2. DATE AND HOUR OF DEATH <b>11/15/70 1:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 GOULD'S CONV. HOME BELAIR RD.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2218 PORTUGAL ST. 105</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1891</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CITY EMPLOYEE</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>MICHAEL BENTKOWSKI</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>MR JOHN BENTKOWSKI</b>			ADDRESS <b>3652 LYNDALE AVE</b>		
18. I <b>412 H I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH <b>Chronic obstructive pulmonary disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS.</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>2/8/67</b> 19 <b>70</b> to <b>1/15</b> 19 <b>70</b> . that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin H. Hixstein M.D.</b>			23B. DATE SIGNED <b>11/15/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. BENJAMIN HIXSTEIN</b>			23D. ADDRESS <b>121 HIGHLAND AVE BALTIMORE MD 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/19/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>		25D. ADDRESS <b>3525 FLEET ST.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00660</u>	
BIRTH NO. <u>70 00660</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>STANLEY LEE OSTER</u>		2. DATE AND HOUR OF DEATH <u>Jan. 17, 1970</u>		Approx. <u>9:30</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21213</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2619 Edison Highway</u>		<u>2643</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/1906</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lieutenant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Frederick Oster</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frederick Oster, son, above</u>			
18. <u>410.9-1 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute coronary thrombosis</u> <u>Arteriosclerotic cardiovascular disease</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>1 1/2 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the <del>deceased</del> ) attended the deceased from <u>April 6, 1963</u> to <u>Jan. 14, 1970</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>S. J. Liu M.D.</u>		23B. DATE SIGNED <u>Jan. 19, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>S. J. Liu, M. D.</u>	
23D. ADDRESS <u>5301 Hatford Road</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/20/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt, Jr.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				ADDRESS <u>3331 Grehms Lane</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00661		REG. NO. 70 00661	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MRS - MARGARET A. COLE</b>				2. DATE AND HOUR OF DEATH <b>1/17/70 11 30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL 4 BALTO. MD. 21223</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21205</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>704 N. Glover St. 702</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/22/25</b>	9. AGE (In years last birthday) <b>43</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Opr.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Esskey</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>HERBERT BENNETT.</b>			
14. MOTHER'S MAIDEN NAME <b>MALTYC Mertyl</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>218-14-2988</b>			
16. SOCIAL SECURITY NO. <b>218-14-2988</b>				17. INFORMANT ADDRESS <b>Robert S. Cole, husband, above</b>			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>235 X I possible myocardial infarction 2 whs</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Qvaran tumour</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> 19 <b>69</b> to <b>1/17</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Orathai Thirawat M.D.</b>				23B. DATE SIGNED <b>1/17/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT MD</b>	
23D. ADDRESS <b>BON SECOURS HOSPITAL BALTO. MD 21223</b>							
24A. BURIAL CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>J. E. F. B. M.D.</b>		25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

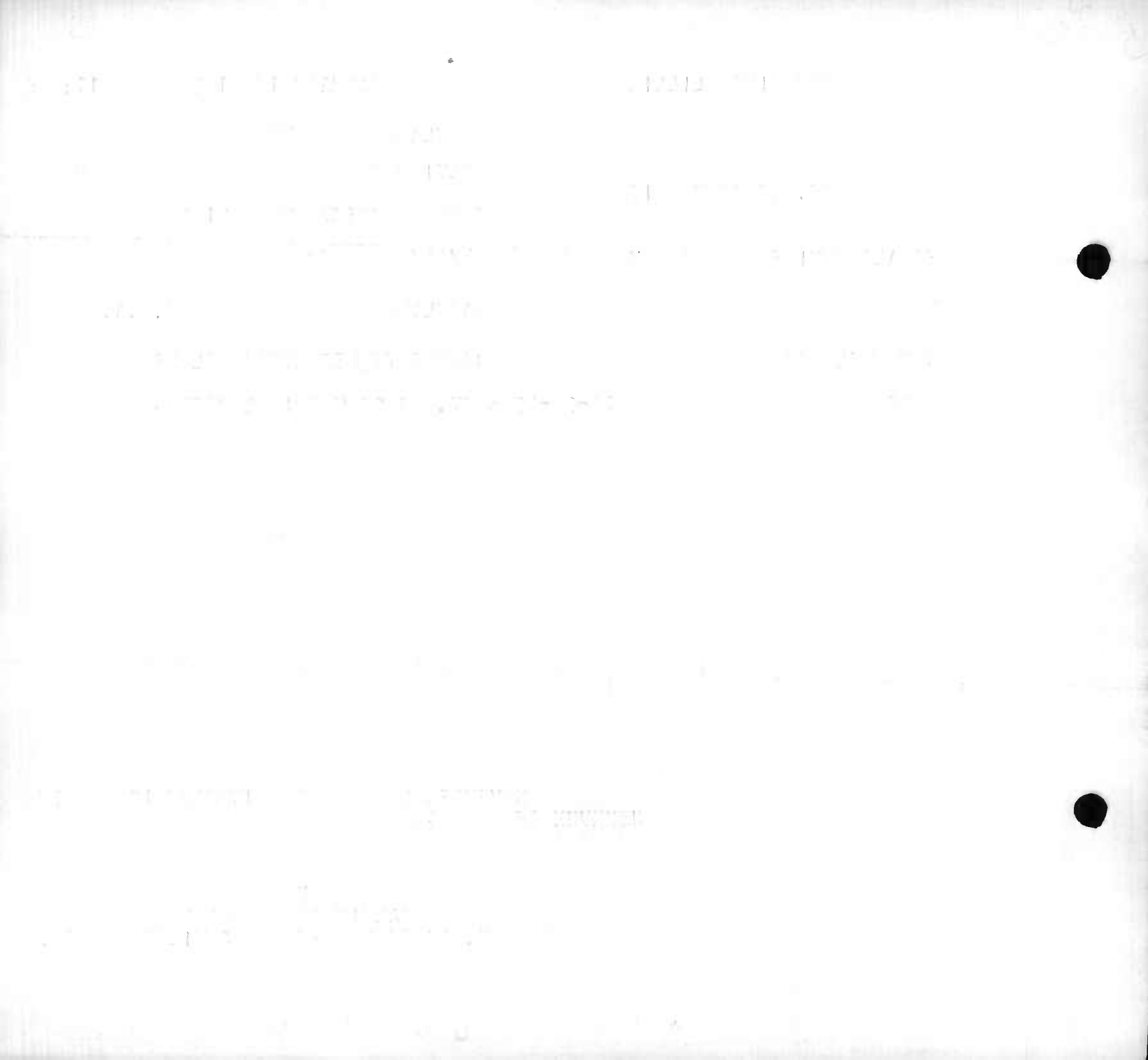
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">70 00662</span>	
70 00662		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JEAN TRAUTMAN</b>		01-14-70 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>		A. STATE <b>MARYLAND</b> U.S.A. <b>Baltimore</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4107 KLAUSMIER ROAD</b> <b>5300</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-13-17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TYPIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. State Health</b>	9. AGE (In years last birthday) <b>52</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>AMERICAN</b>	
13. FATHER'S NAME <b>SAMUEL RAINALDI</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Marie Mannella</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>220-09-6202</b>	
17. INFORMANT <b>HERSELF</b>		ADDRESS	
18. <b>390.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Pyelonephritis</b> <b>CS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic Pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CS</b>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>			
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-17</b> 19 <b>69</b> to <b>01-14</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>01-14</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>G. Yamazaki M.D.</b>		23B. DATE SIGNED <b>01-14-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>YAMASAKI, YASUMASA M.D.</b>		23D. ADDRESS <b>33RD AND CALVERT STREET</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-1970</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road 21236</b>	

Chas. H. Johnson  
1880

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 00663	
BIRTH NO. 70 00663				1. NAME OF DECEASED (Type or Print) SUCHTING, LILLIAN M		2. DATE AND HOUR OF DEATH JANUARY 15, 1970 11:00A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years last birthday) 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				A. STATE MARYLAND		B. COUNTY BALTO	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 5 NO PROSPECT AVE 21228			
6. SEX FEMALE	7. RACE WHITE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 04/27/00	10. AGE (In years last birthday) 69	11. Under 1 Yr. Months Days	12. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN WELKNER		14. MOTHER'S MAIDEN NAME JEANNETTE (NEE MYERS) WELKNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 215-30-1728		17. INFORMANT ADDRESS 8 ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH				19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia			
				(B) SECONDARIES - METASTATIC DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 28 19 69 to JANUARY 15 19 70 that (I) (we) last saw the deceased alive on JANUARY 15 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Veena Govila				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-70		24C. NAME of CEMETERY or CREMATORY St. Pauls Church Cemetery		24D. LOCATION (City, town, or county) (State) Viatorville - Balto - Md - 21228	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1970		25B. NAME OF REGISTRAR _____		25C. FUNERAL DIRECTOR _____		ADDRESS _____	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

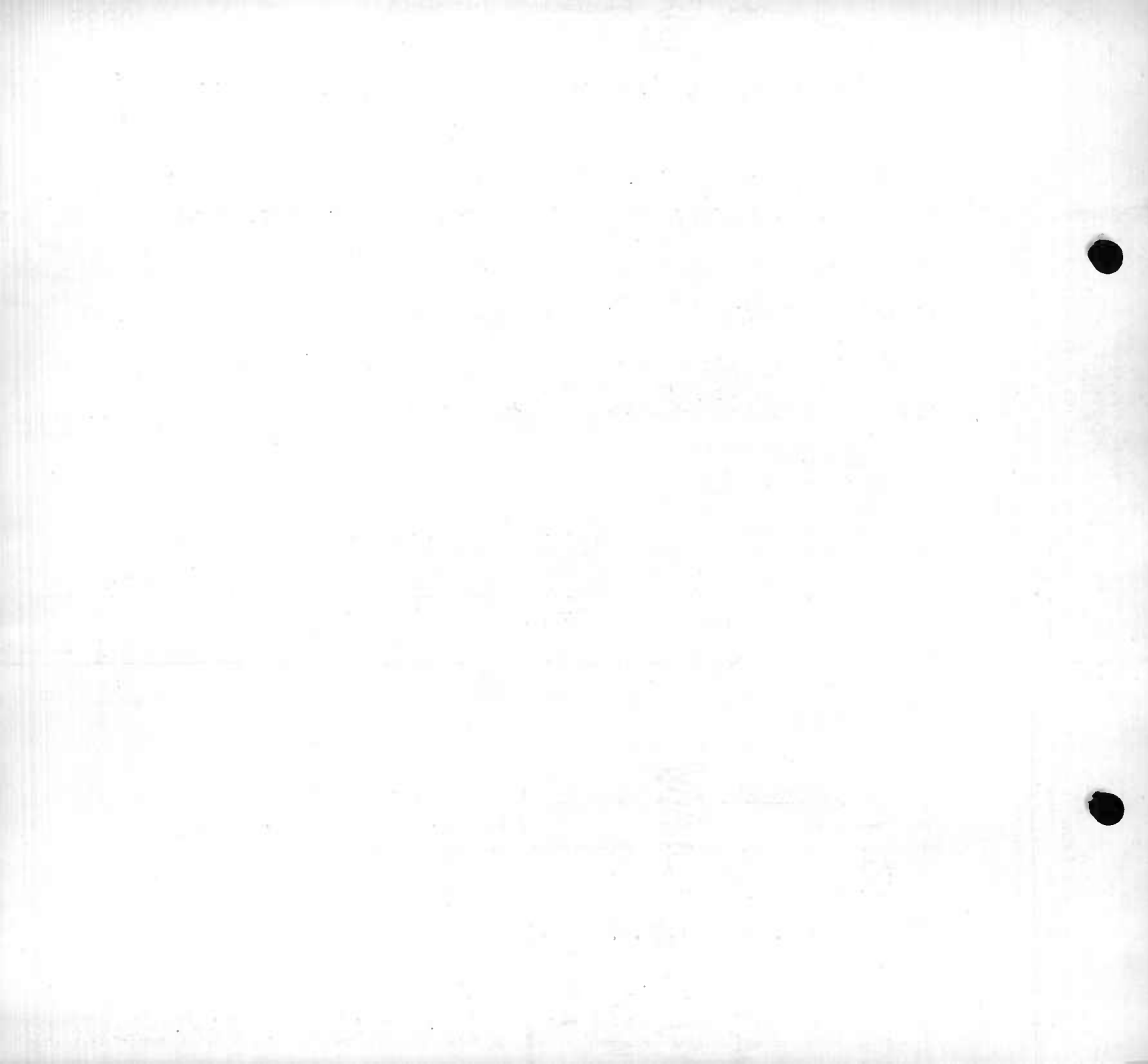
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00664</u>
BIRTH NO. <u>70 00664</u>		1. NAME OF DECEASED (Type or Print) <u>REED ALMA E</u>		
2. DATE AND HOUR OF DEATH <u>1/13/70</u> <u>955 P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		
C. CITY OR TOWN <u>Aberdeen</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>47 Liberty Street</u> <u>21001</u>		5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH <u>5-7-26</u>		9. AGE (In years last birthday) <u>43</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed Days Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John E. Reed</u>		
14. MOTHER'S MAIDEN NAME <u>Beulah Reed Jones</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		
16. SOCIAL SECURITY NO. <u>219-56-4906</u>		17. INFORMANT <u>4940 Eastern Avenue</u> BCH: Records Baltimore, Maryland 21224		
18. CAUSE OF DEATH <u>427.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>cardiorespiratory arrest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>39 hr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>uremia</u>				<u>unknown</u>
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>1/11/70</u> 19 to <u>1/13/70</u> 19 that (1) (we) last saw the deceased alive on <u>1/13/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Dale P. Henken, M.D.</u>		23B. DATE SIGNED <u>1/13/70</u>		23C. PHYSICIAN'S NAME (Type) <u>DALE P. HENKEN M.D.</u>
23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>1-19-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Darlington, Harford Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>E. J. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Esther J. Bullock, Haven de Grace, Md.</u>

07-4.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00665	
BIRTH NO. 70 00665		70 00665 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GEORGE J. YOUNG</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 15, 1970 7:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>GOULD CONVALESCARIUM</b>		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90 6116 BELAIR Rd.		E. STREET AND NUMBER <b>5118 ARDMORE Way 2741</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1900</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CHECKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MOTOR FREIGHT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>		13. FATHER'S NAME <b>JOSEPH YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>MARY KENNEDY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 4-15-1919 4-14-22</b>		16. SOCIAL SECURITY NO. <b>216-10-0870</b>		17. INFORMANT <b>FAMILY</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>344.1 I Cachexia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple draining decubitus ulcers</b>		<b>2 mo.</b>	
		(B) <b>Right Hemiplegia</b>		<b>3 mo.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Right Pneumonia Recurrent Urinary Tract Infection</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1/9/1970</b> to <b>1/15/1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/14/1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>1/16/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALBERT B. BRADLEY, M.D.</b>		23D. ADDRESS <b>4900 BELAIR ROAD 21206</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-19-70</b>		24C. NAME of CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John Walter Conklin</b>	
				ADDRESS <b>5444 BELAIR Rd.</b>	

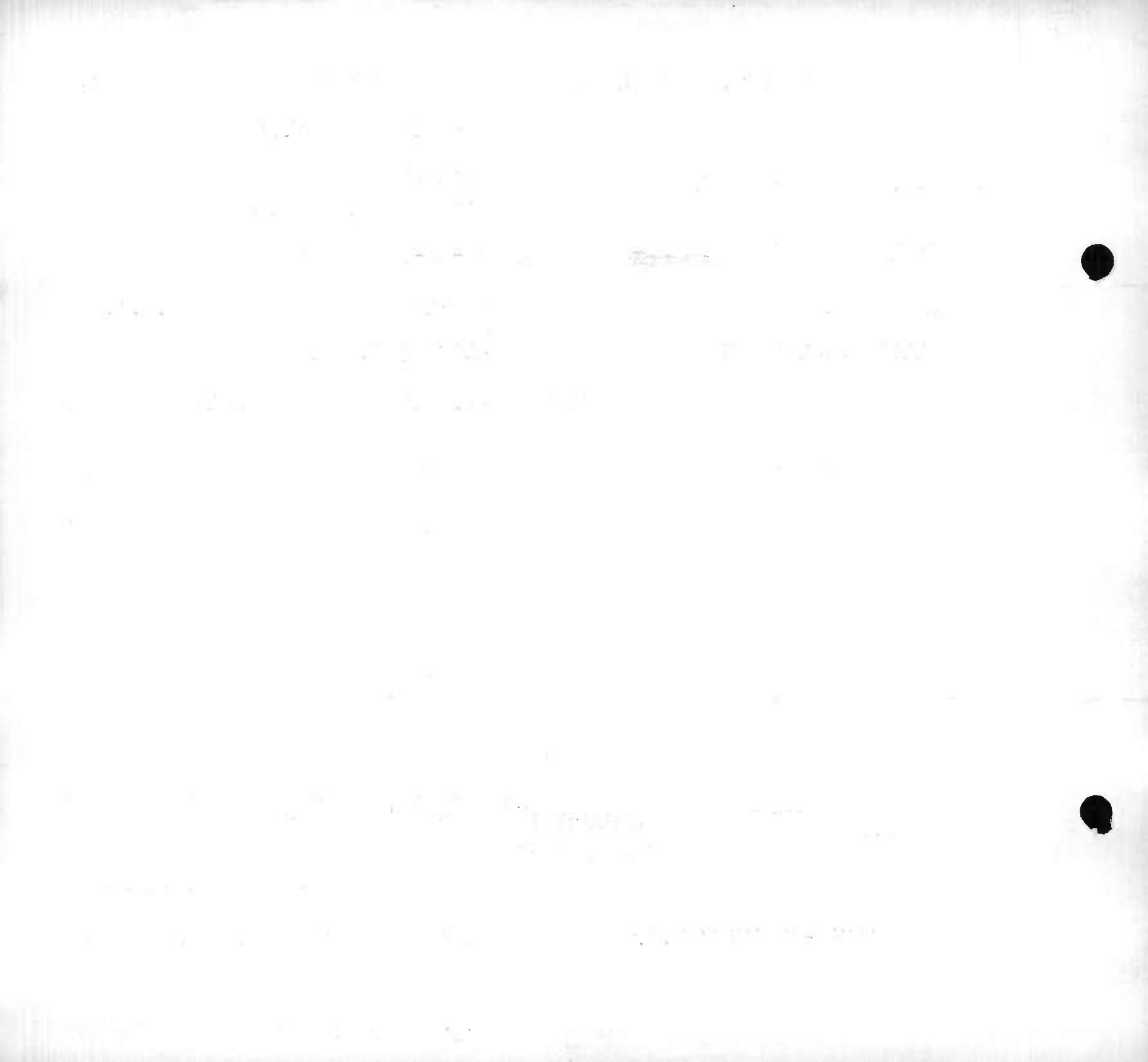




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00666		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00666	
1. NAME OF DECEASED (Type or Print) <b>STATES, ANITA LAURA</b>			2. DATE AND HOUR OF DEATH <b>01/18/70 1:45P</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> 8. DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>12-25-08</b> 9. AGE (in years last birthday) <b>61</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>WILLIAM PAUL IHRIE</b>			14. MOTHER'S MAIDEN NAME <b>ALICE (DELONE)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220 14 7839</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS BALTO MD 21229</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Heart Attack (MI)</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>Several</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>JANUARY 18, 1970</b> to <b>JANUARY 18, 1970</b> that <b>(X)</b> (we) last saw the deceased alive on <b>JANUARY 18, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bizhan - Ebrahimi M.D.</b>			23B. DATE SIGNED <b>01 18 70</b>		23C. PHYSICIAN'S NAME (Type) <b>BIZHAN-EBRAHIMI M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>1-21-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK CEMETERY</b>
24D. LOCATION <b>BALTIMORE CITY</b>			24E. LOCATION <b>MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>1-21-1970</b>		25B. NAME OF REGISTRAR <b>210 E. Baltimore Ave.</b>		25C. FUNERAL DIRECTOR <b>H. H. HUBBARD</b>	
25D. ADDRESS <b>4105 Wilkens Ave.</b>		25E. ADDRESS <b>21229</b>			



7-1-6431  
1/18/70 RELEASED HCO  
1/18/70  
MEDICAL EXAM. INFORMED  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00667	
BIRTH NO. 70 00667				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>WILLARD DARLETON</i>		2. DATE AND HOUR OF DEATH <i>1/18/70 6:05 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIV. OF MD. HOSP BALTO. MD.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>MD</i> B. COUNTY <i>A. A. C. 52-00</i>			
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cab Co.</i>		8. DATE OF BIRTH <i>12-10-13</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		9. AGE (In years last birthday) <i>56</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>W. I. I. A. R. D.</i>		14. MOTHER'S MAIDEN NAME <i>L. A. C. I. A. W. I. T. E. N.</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>		ADDRESS <i>W. I. I. A. R. D.</i>	
18. <i>571.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CIRRHOSIS</i>  (B) <i>ALCOHOLISM</i> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>YRS</i>  <i>YRS.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/18/70</i> 19 to <i>1/18/70</i> 19, that (I) (we) last saw the deceased alive on <i>1/18/70</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Larry D. Wheeler</i> M.D. OEGREE				23B. DATE SIGNED <i>1/18/70</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1/21/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Solomon's</i>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <i>6-130 E. F. O. C. S.</i>	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR	

Handwritten text, possibly a date or reference number, located in the upper left quadrant.

Handwritten text, possibly a date or reference number, located in the upper right quadrant.

Handwritten text, possibly a date or reference number, located in the middle left quadrant.

Handwritten text, possibly a date or reference number, located in the middle center quadrant.

Handwritten text, possibly a date or reference number, located in the middle right quadrant.

Handwritten text, possibly a date or reference number, located in the lower left quadrant.

Handwritten text, possibly a date or reference number, located in the lower center quadrant.

Handwritten text, possibly a date or reference number, located in the lower center quadrant.

Handwritten text, possibly a date or reference number, located in the lower right quadrant.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655 1

70 00668

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 00668

BIRTH NO.		70 00668	
1. NAME OF DECEASED (Type or Print) <b>EUGENE B. BRANHAM</b>		2. DATE AND HOUR OF DEATH <b>1/17/70 1 6<sup>00</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b> <b>BALTIMORE MARYLAND</b>		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>819 WASHINGTON BLVD. 2102</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/198</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C &amp; O RAILROAD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	9. AGE (In years last birthday) <b>71</b>
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDMOND BRANHAM</b>		14. MOTHER'S MAIDEN NAME <b>ELENA WILLIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes World War 1</b>		16. SOCIAL SECURITY NO. <b>8857838</b>	
17. INFORMANT <b>Mrs. Euna Nelson</b>		ADDRESS <b>819 Washington Blvd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>154.1 I</b> <b>225.01 9025</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DNE YEAR</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>ADENOCARCINOMA OF THE RECTUM WITH PERFORATION, PELVIC ABSCESS &amp; 2° ENTEROVESICLE FISTULA</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>12/4/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BOWEL PERFORATION</b>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 2 1970</b> to <b>JAN 17 1970</b> that (I) (we) last saw the deceased alive on <b>JAN 16 1970</b> and that (I) (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Neil Mark Keats M.D.</b>		23B. DATE SIGNED <b>1/17/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>UNIVERSITY HOSPITAL BALT. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Raymond C. Fink</b>	
25C. FUNERAL DIRECTOR <b>Glen Burnie, Md.</b>		ADDRESS	

1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

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1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

1941-1942 2. 10. 1942

70 00669

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 00669

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ADAMS, ANNIE (ANNA)

2. DATE AND HOUR OF DEATH

1-18-70

12:00 noon M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3238 E. Baltimore St. 21224 007 2610

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7-15-84-1881

9. AGE (In years  
last birthday)

85-88

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Lindeman

14. MOTHER'S MAIDEN NAME

MARY E. SERT

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

216-05-5548

17. INFORMANT

BCH-Records 4940 Eastern Avenue  
Baltimore, Maryland 21224

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. CAUSE WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 1/12/70 19 to 1/18/70 19  
 that (1) (we) last saw the deceased alive on 1/18/70 19 and that in (my) (our) opinion death occurred on the date  
 and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J.R. Wands MD

DEGREE

Attending  
Phys.Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/18/70

23C. PHYSICIAN'S  
NAME (Type)

J.R. Wands

MD, DEGREE

23D. ADDRESS

BCH- 4940 Eastern Avenue  
Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-22-70

24C. NAME of CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Helen A. Hoffman

ADDRESS

3218 Hudson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from Social Security and V.S. 153  
1-23-70 M.H.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

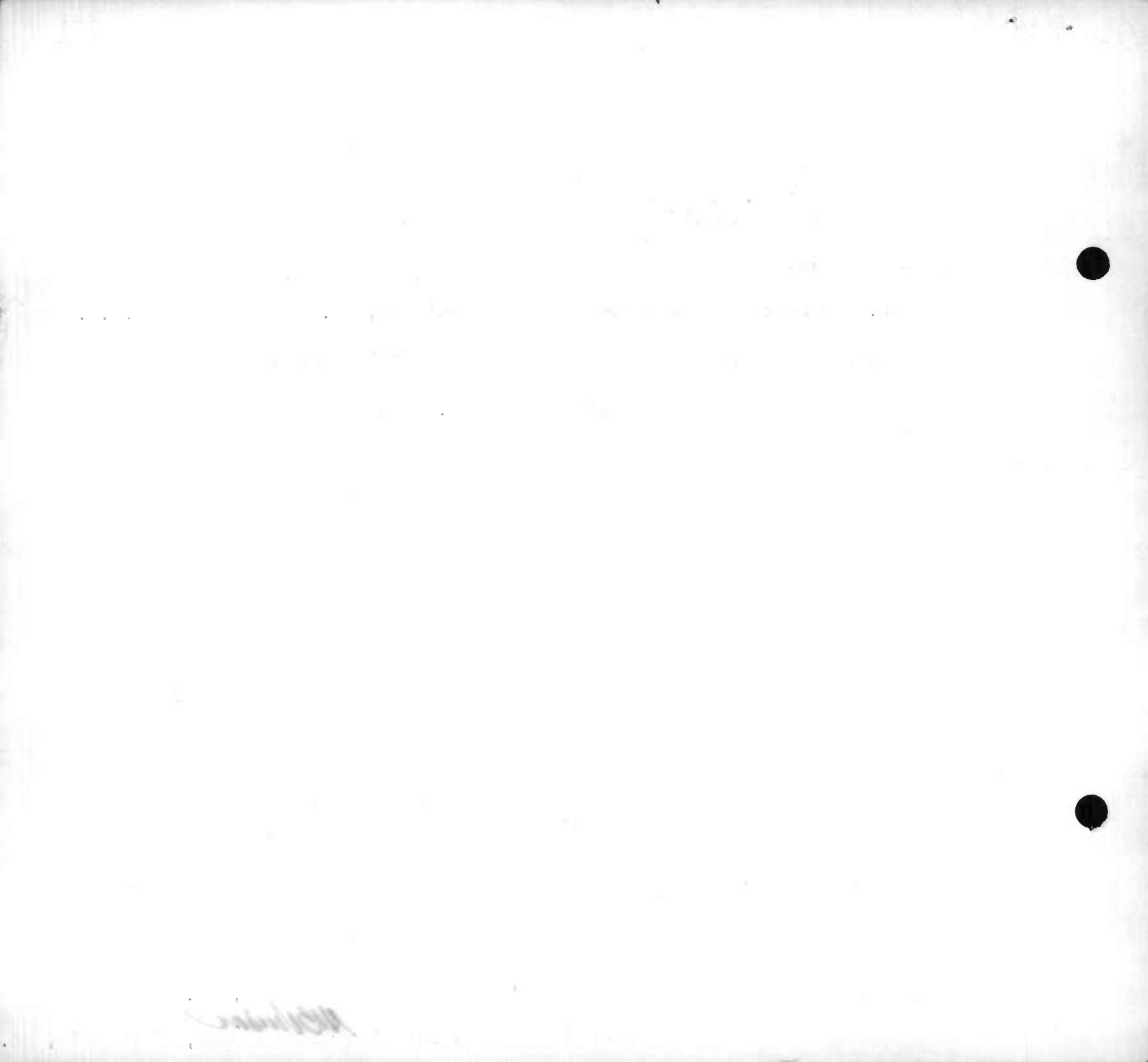
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00670</span>	
BIRTH NO. <span style="float: right;">70 00670</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM DAVIES</b>		2. DATE AND HOUR OF DEATH <b>1-15-70 - 7:00 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>		A. STATE <b>MD.</b>		B. COUNTY <b>ANNE ARUNDEL</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42</b>		C. CITY OR TOWN <b>Glen Burnie</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>225 Kuethe Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 1, 1893</b>	9. AGE (in years lost birthday) <b>76</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman (Ret)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alfred DAVIES</b>			
14. MOTHER'S MAIDEN NAME <b>MARY MIKE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>			
16. SOCIAL SECURITY NO. <b>215-07-9821</b>		17. INFORMANT <b>Mrs Viola M. Davies</b>			
18. <b>185X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Generalized metastatic carcinoma + 6 years?			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prostatic Carcinoma</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6 mos ago</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>suprapubic prostatectomy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-31-69</b> to <b>1-15-70</b> and that (I) (we) last saw the deceased alive on <b>1-15-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE <b>Jose Sagbini MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-15-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE SAGBINI MD</b>		23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Airy Cemetery</b>	
24D. LOCATION <b>Elkridge, B&amp;E Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>			
25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>W. B. Johnson</b>			
		ADDRESS <b>1000 E. J. Taylor Rd.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

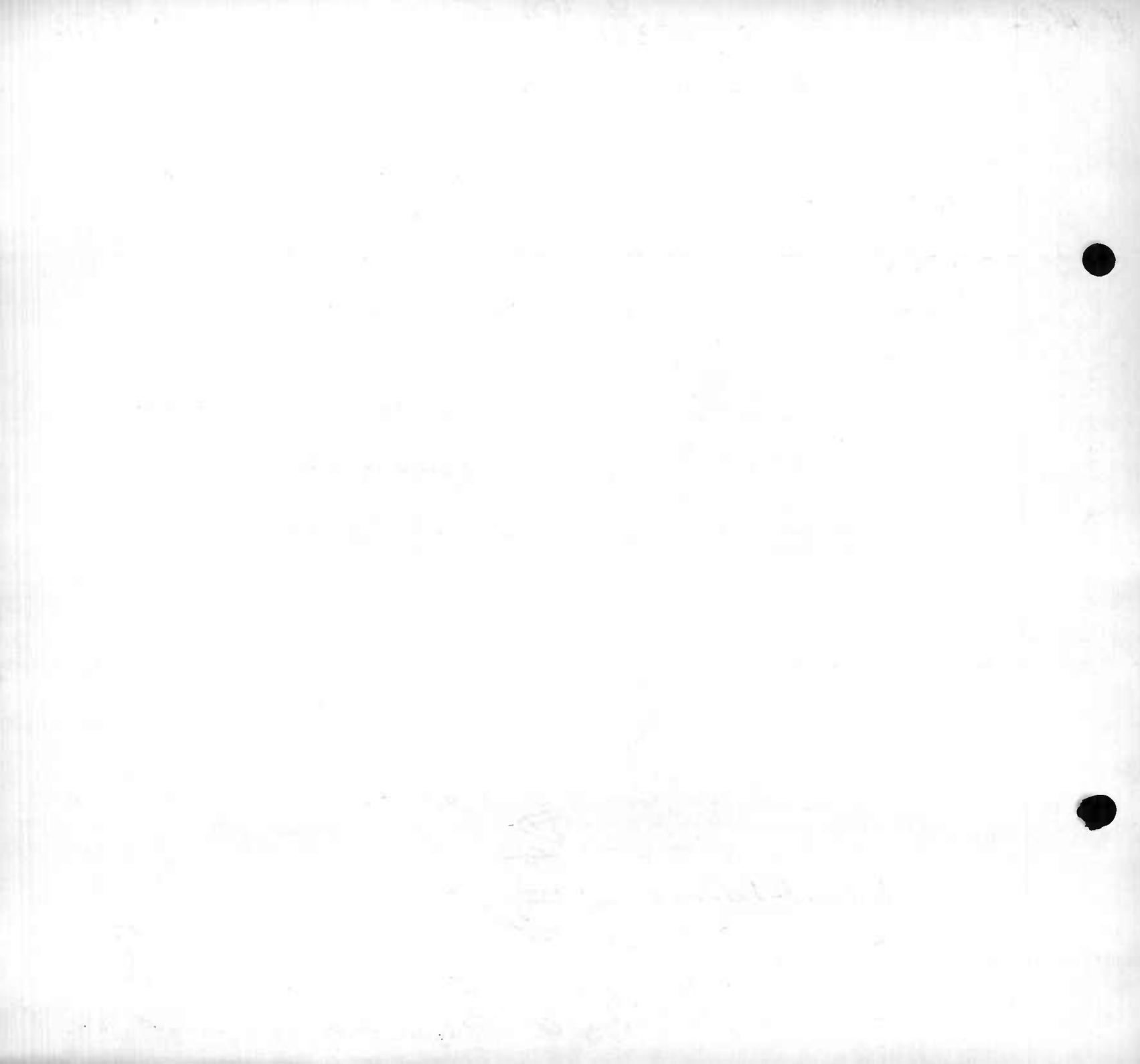
BALTIMORE CITY HEALTH DEPARTMENT				70 00671		CERTIFICATE OF DEATH		70 00671	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				OFFLEY ROGER A.		1-17-70		2:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		Anne Arundle 52-00	
33				JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE, MD		C. CITY OR TOWN PASADENA		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE				WHITE				05 12 41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday)		11. BIRTHPLACE (State or foreign country)	
Ins. Adjuster				Insurance		28		Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
WARREN OFFLEY				EVELYN WATTS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				NONE		217/38/8193		Mrs. Joan Offley Same as #4	
18. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				I					
				Embryonal Cell Carcinoma of Left Testis					
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
				ANTECEDENT CAUSES					
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
				II					
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None						yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from				1/17 1970		to		1/17 1970	
that (I) (we) last saw the deceased alive on				1/17/70		1970		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
R. Veseuda				1/17/1970		R. Veseuda M.D.		Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				1/21/70		Glen Haven Mem'l Park		Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 21 1970				R. E. Talbot, M.D.		O. Singleton		Funeral Home, Glen Burnie, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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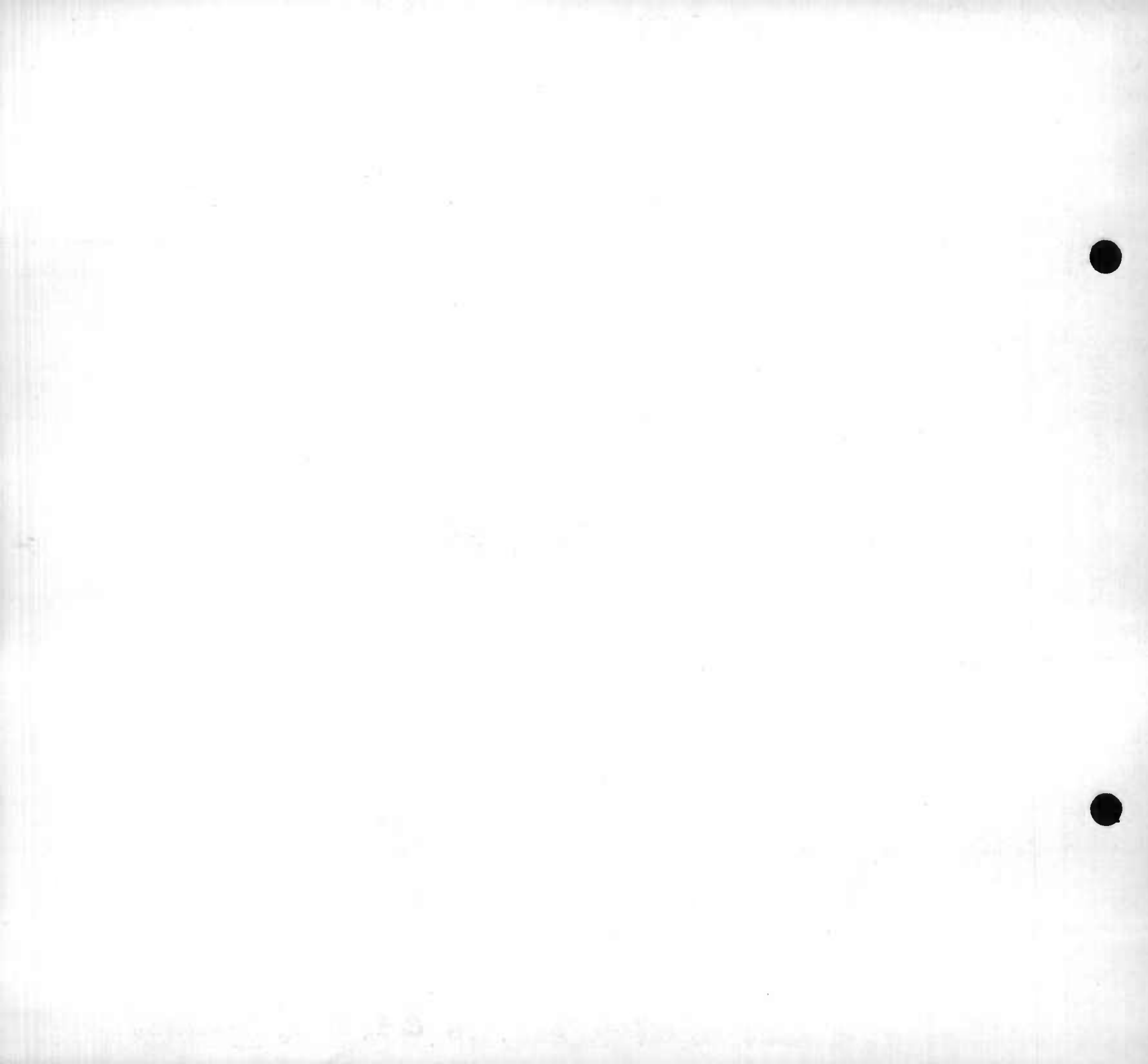
BALTIMORE CITY HEALTH DEPARTMENT									
70 00672 CERTIFICATE OF DEATH					REG. NO. 70 00672				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>LOUIS J. HRANICKA</b>					JANUARY 18, 1970 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 4823 PENNINGTON AVE</b>					A. STATE <b>MARYLAND</b>				
					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>AUG. 5 - 1906</b> 9. AGE (In years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Balti City Police Dpt</b>					11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANK HRANICKA</b>					14. MOTHER'S MAIDEN NAME <b>MARY SHETLIK</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Fam. / 1</b> ADDRESS <b>Sen</b>		
18. <b>396.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Anterior &amp; lateral wall MI</b>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Embolism</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
19. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Apr 18 57</b> 19 to <b>1/2/70</b> 19, that (I) (we) lost saw the deceased alive on <b>1/2/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Andrew R. Sosnowski</b> M.D. DEGREE					23B. DATE SIGNED <b>1/19/70</b>			23C. PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b> M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>JAN 22 - 70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. 21225, MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>					25B. NAME OF REGISTRAR <b>Robert E. Gable</b>		25C. FUNERAL DIRECTOR <b>John H. HAMM</b> ADDRESS <b>4200 Pennington Ave</b>		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00673	
<div> <div>70 00673</div> <div>CERTIFICATE OF DEATH</div> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA T. KUEBLER		JAN. 18 - 1970 12:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3825 ST. MARGARET ST.			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3825 ST. MARGARET ST. 2505		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	JAN. 7 - 1883	87	Housewife
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
BALTO.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HENRY DENHARDT			ELIZABETH Rodenmeyer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			FAMILY		
17. INFORMANT			ADDRESS		
FAMILY			Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
412.21			Arteriosclerotic CVD		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Hypertension		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			10 yrs		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 40 to 1-18 19 70, that (I) (we) last saw the deceased alive on 1-17 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Duerr Moore M.D.				1-19-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. DUERR MOORES M.D.				3105 Belair Rd Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-21-70		Holy Cross Cemtry	
24D. LOCATION (City, town, or county)		24E. STATE		24F. FUNERAL DIRECTOR	
Balto. 21225, Md.				John H. Wahn, 4200 PENNINGTON Ave.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1970		Robert E. Taylor, M.D.		John H. Wahn, 4200 PENNINGTON Ave.	

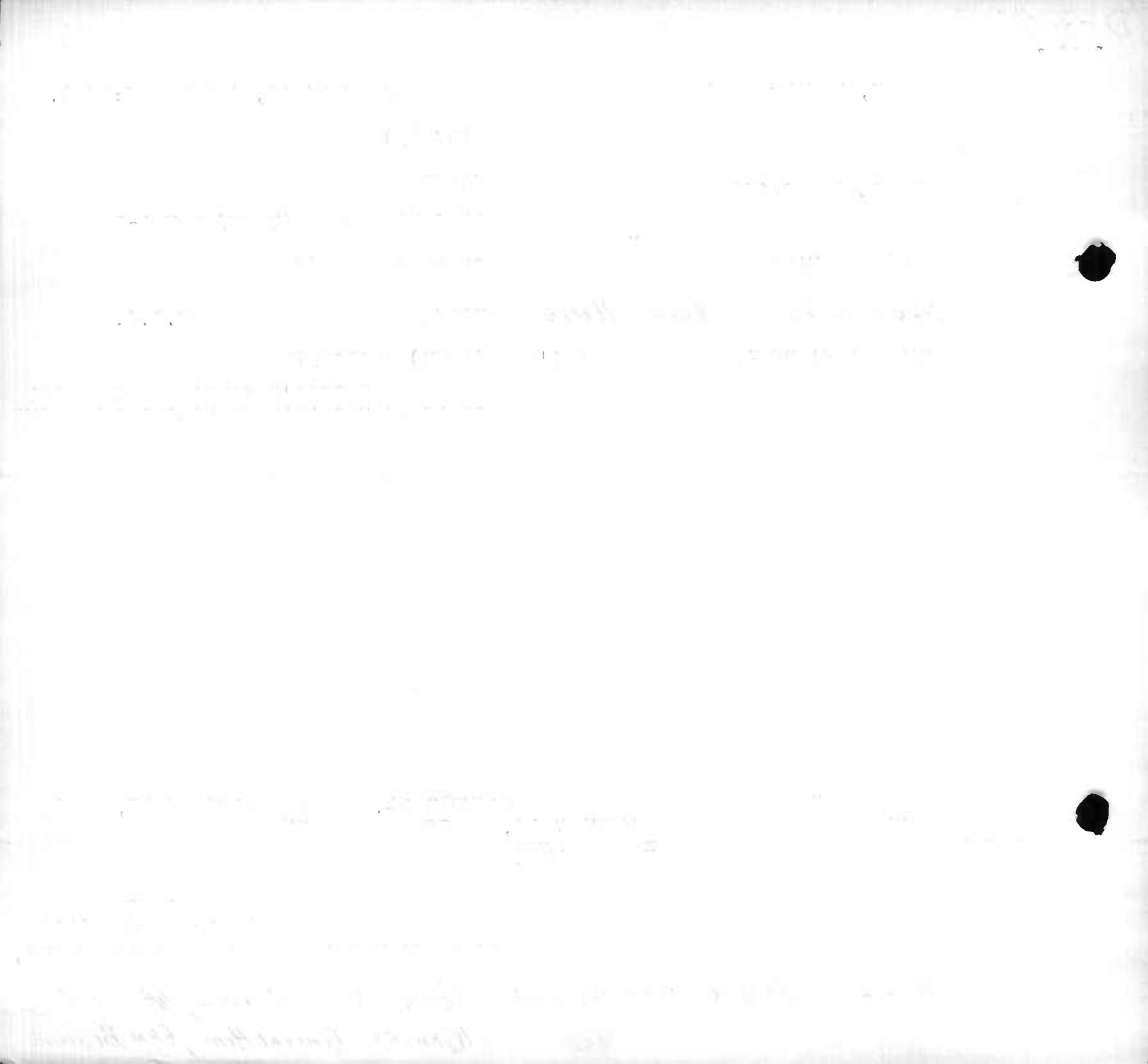




# FUNERAL DIRECTOR: IMPORTANT

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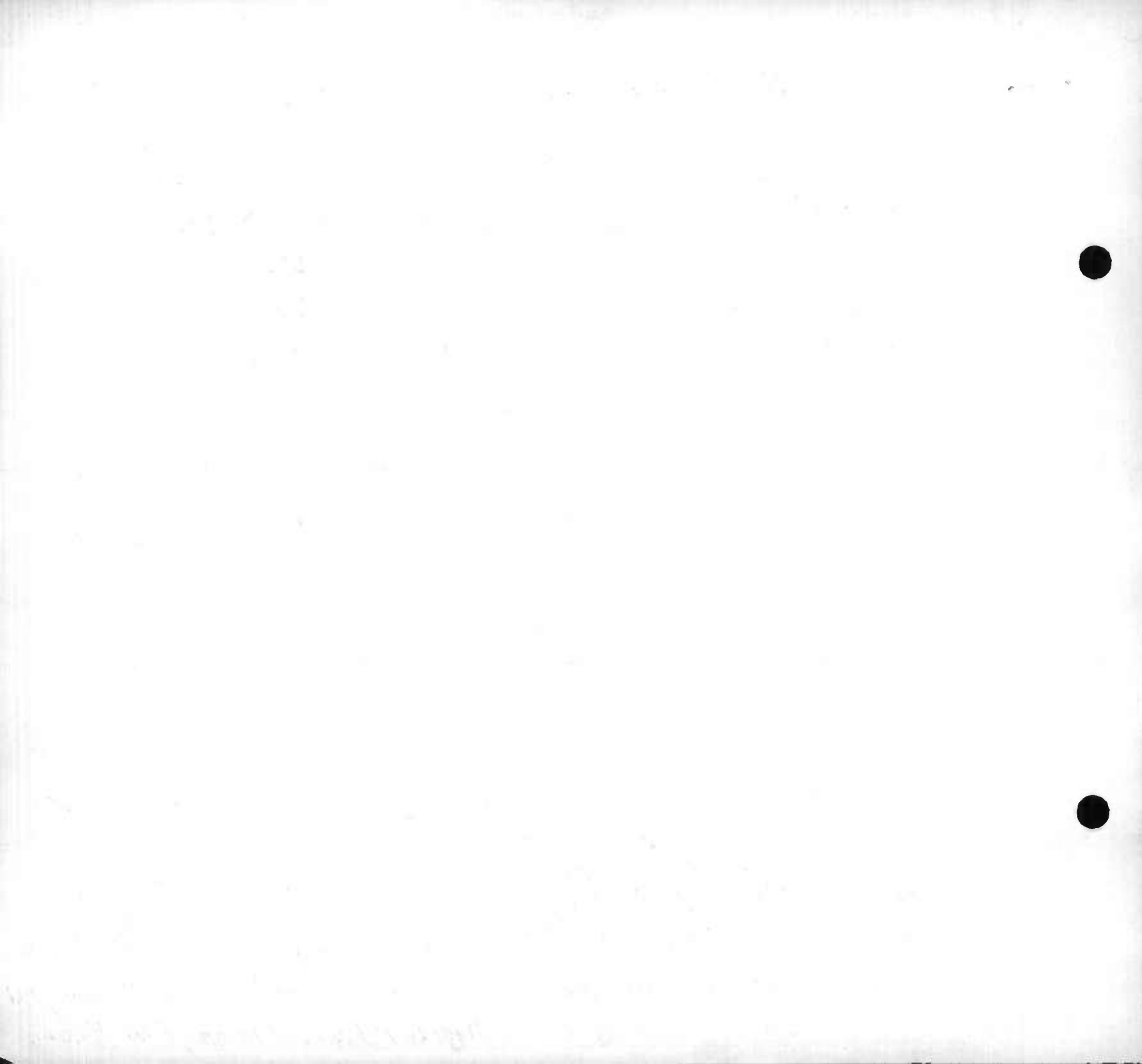
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00674	
BIRTH NO. 70 00674				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>DOODY, LOUISE EMMA</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 15, 1970   5:45 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b> <b>40</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2400 MARBOURNE AVENUE APT 1-B 2572</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03/22/09</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>CHARLES BINDEMAN</b>		
14. MOTHER'S MAIDEN NAME <b>DEC'D (ROTH) ELIZABETH</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b> <b>Pneumonitis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>DECEMBER 24, 1969</b> to <b>JANUARY 15, 1970</b> that (X) (we) last saw the deceased alive on <b>JANUARY 15, 1970</b> and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>John - Marsh</b>			23B. DATE SIGNED <b>1-15-70</b>		23C. PHYSICIAN'S NAME (Type) <b>M.G. ALLEN-MERSH, M.D.</b>
23D. ADDRESS <b>BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			23E. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/19/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>	
24D. LOCATION <b>Glen Burnie, MD</b>		24E. FUNERAL DIRECTOR <b>KIRKLEY Funeral Home</b>		24F. ADDRESS <b>Glen Burnie</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

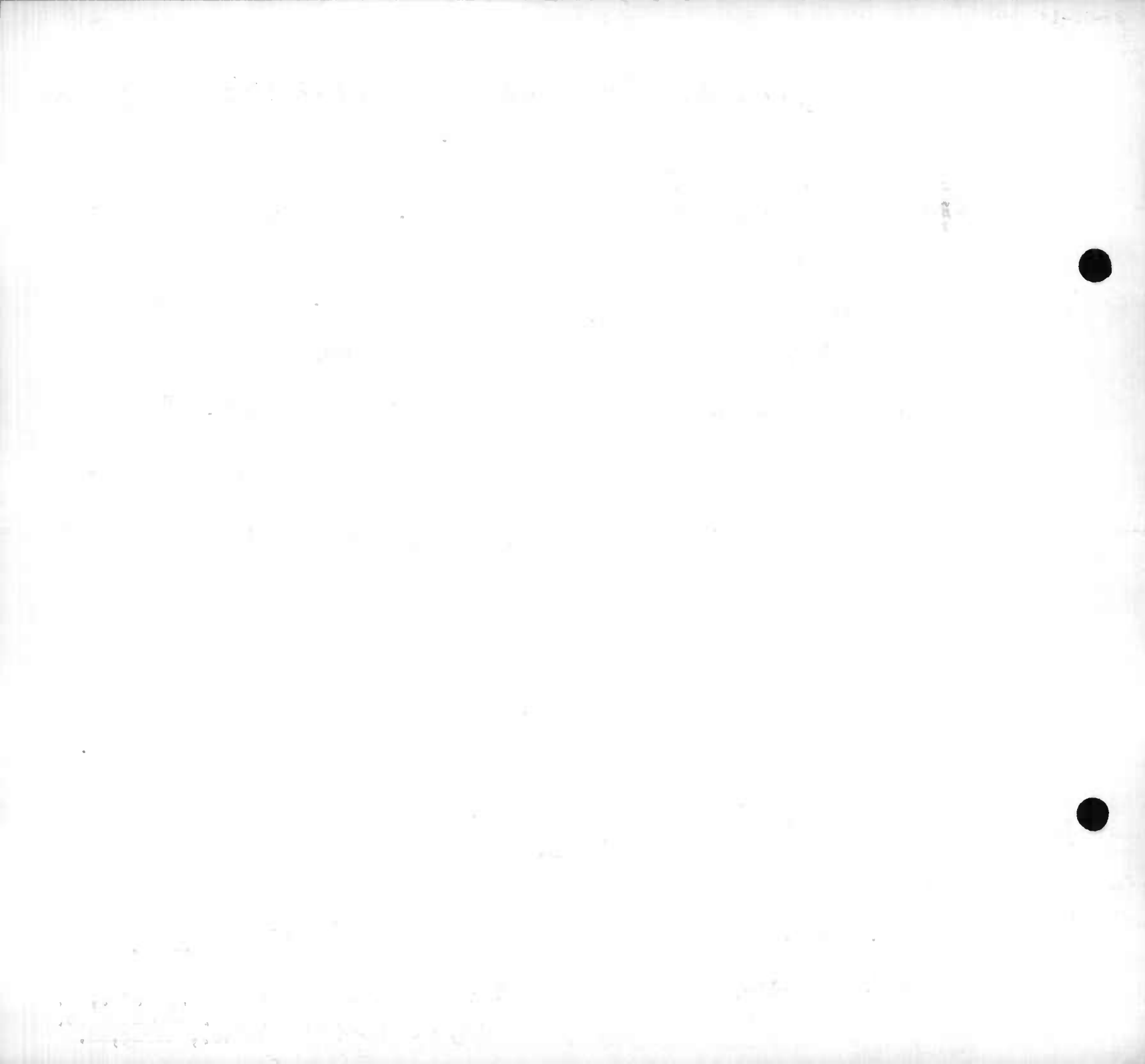
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
70 00675		70 00675		70 00675		70 00675	
1. NAME OF DECEASED (Type or Print) <b>ADA P. STRAUSSER -</b>				2. DATE AND HOUR OF DEATH <b>1-14-70 2:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MONTEBELLO STATE HOSP BALT. MD.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSP BALT. MD.</b>				C. CITY OR TOWN <b>GLEN BURNIE.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>812 CEDAR BEACH DRIVE -</b>							
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-16.</b>	9. AGE (In years last birthday) <b>53.</b>	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>U.S. PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WM. SCHWARTZ</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE EISENHOWER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>170-220464</b>		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CARCINOMATOSIS -</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MO.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA OF CERVIX.</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>3 + YRS.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>RT. HEMIPLEGIA -</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>5 MO.</b>			
19A. DATE OF OPERATION <b>2.</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-7</b> 19 <b>69</b> to <b>1-14</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1-14</b> 19 <b>70</b> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Raymond W. Herrmann MD</b>				23B. DATE SIGNED <b>1/14/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>RAYMOND W. HERRMANN MD</b>				23D. ADDRESS <b>MONTEBELLO STATE HOSP. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/17/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>BALT. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>W. K. F. Funeral Home, Glen Burnie</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

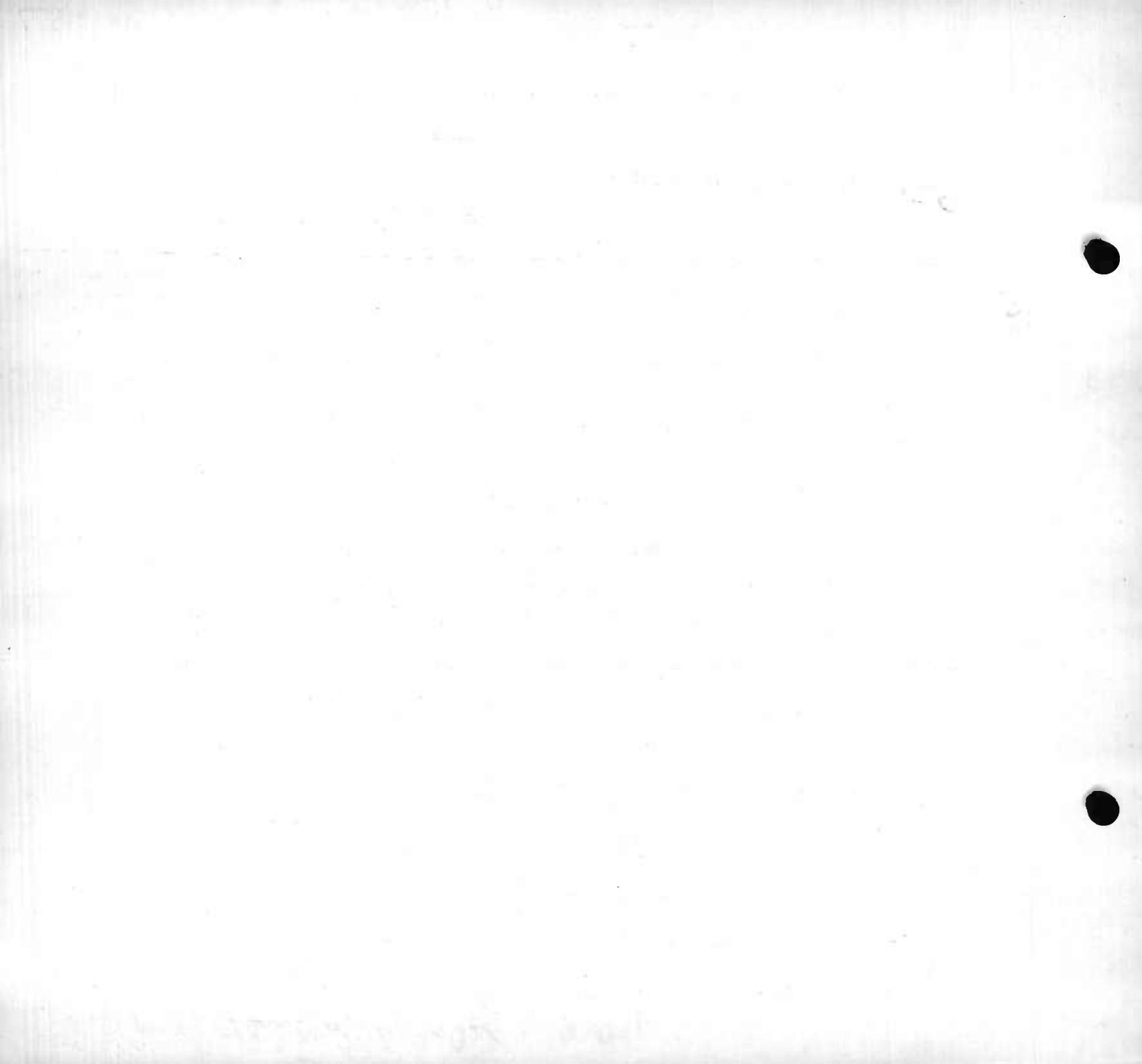
39-30-14 TB		BALTIMORE CITY HEALTH DEPARTMENT		70 00676	
BIRTH NO.		70 00676		REG. NO. 70 00676	
1. NAME OF DECEASED (Type or Print) <u>Elizabeth Brune</u>			2. DATE AND HOUR OF DEATH <u>1/16/70</u> <u>3:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>6/10/90</u>			9. AGE (In years last birthday) <u>79</u>		10. Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>David Fogle</u>			14. MOTHER'S MAIDEN NAME <u>Christine</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>BCH Records: 4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>
18. <u>154.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cardiac Arrest</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Probable Rectal Ca</u> (B) <u>?</u> (C) <u>?</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> 19 <u>70</u> to <u>1/16</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack D. McCue</u>			23B. DATE SIGNED <u>1/16/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Jack D. McCue</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1-20-70</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>7225 Eastern Blvd., Ba. Co., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>			25B. NAME OF REGISTRAR <u>Charles J. Jester</u>		
25C. FUNERAL DIRECTOR <u>901 S. Conkling St.</u> <u>Balto., 21224, Md.</u>			25D. ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00677				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 26 70 00677			
1. NAME OF DECEASED (Type or Print) <u>Schleibaum Jeanette</u>				2. DATE AND HOUR OF DEATH <u>1-19-70</u> <u>4:45 P.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>aa Co.</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View H.C.C.</u> <u>90</u>				C. CITY OR TOWN <u>Linthicum Hgts</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>31 Patapsco Rd.</u> <u>5200</u>							
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-86</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>George Kimmelschue</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Moser</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Thelma Perry 3 Patapsco Rd.</u> <u>21090</u>			
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Cerebral Thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Arteriosclerotic Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardiovascular Disease</u> <u>years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Cardiovascular Disease</u> <u>years</u>											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (the hospital) attended the deceased from <u>Jan 28</u> 19 <u>69</u> to <u>Jan 19</u> 19 <u>70</u> , that (2) (we) last saw the deceased alive on <u>Jan 19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
23A. SIGNATURE <u>A. C. Aleuizatos, M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>Jan 19, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>A. C. ALEUIZATOS, M.D.</u>				23D. ADDRESS <u>1209 SA Paul St. Baltimore 21202</u>							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <u>1/21/70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Linden Park Cem. Baltimore Md.</u>			
24D. LOCATION (City, town, or county) (State) <u>Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>			
25C. FUNERAL DIRECTOR <u>W. G. Kelly, F.H.</u>				25D. ADDRESS <u>737 Patapsco Ave. Baltimore Md.</u>							





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70 00678

BALTIMORE CITY HEALTH DEPARTMENT

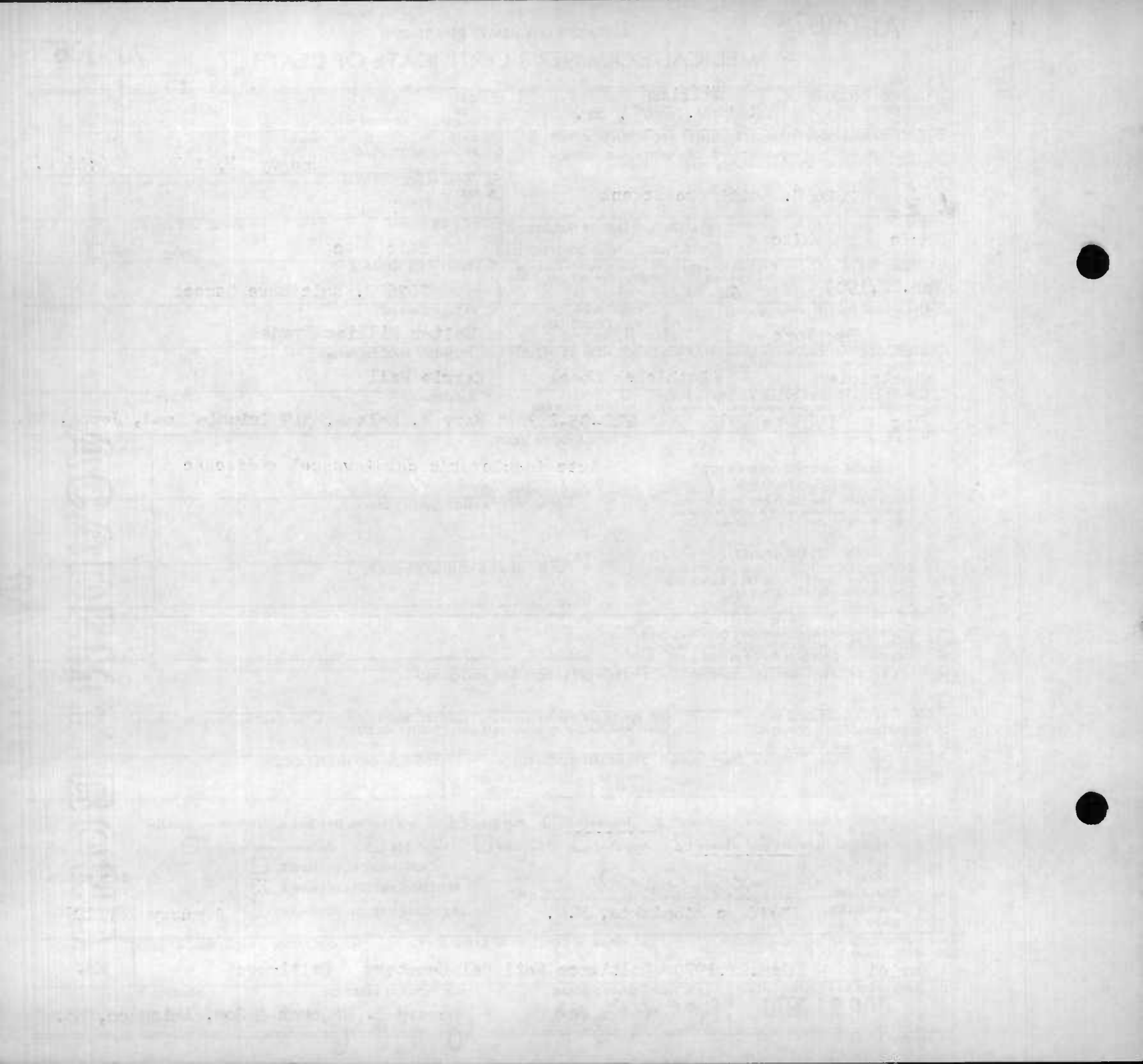
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00678

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>William JESSE W. EVANS, Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2026 E. Baltimore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 17, 1970 6:25 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		6. SEX <b>Male</b> 7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 22, 1909</b> 10. AGE (in years last birthday) <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter William Evans</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		15. MOTHER'S MAIDEN NAME <b>Carrie Hall</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1925 to 1937</b>		17. SOCIAL SECURITY NO. <b>220-95-2878</b>	
18. INFORMANT <b>Mary E. Nelson, 519 Trimble Road, Joppa, Md.</b>		ADDRESS	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>January 18, 1970</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 21, 1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

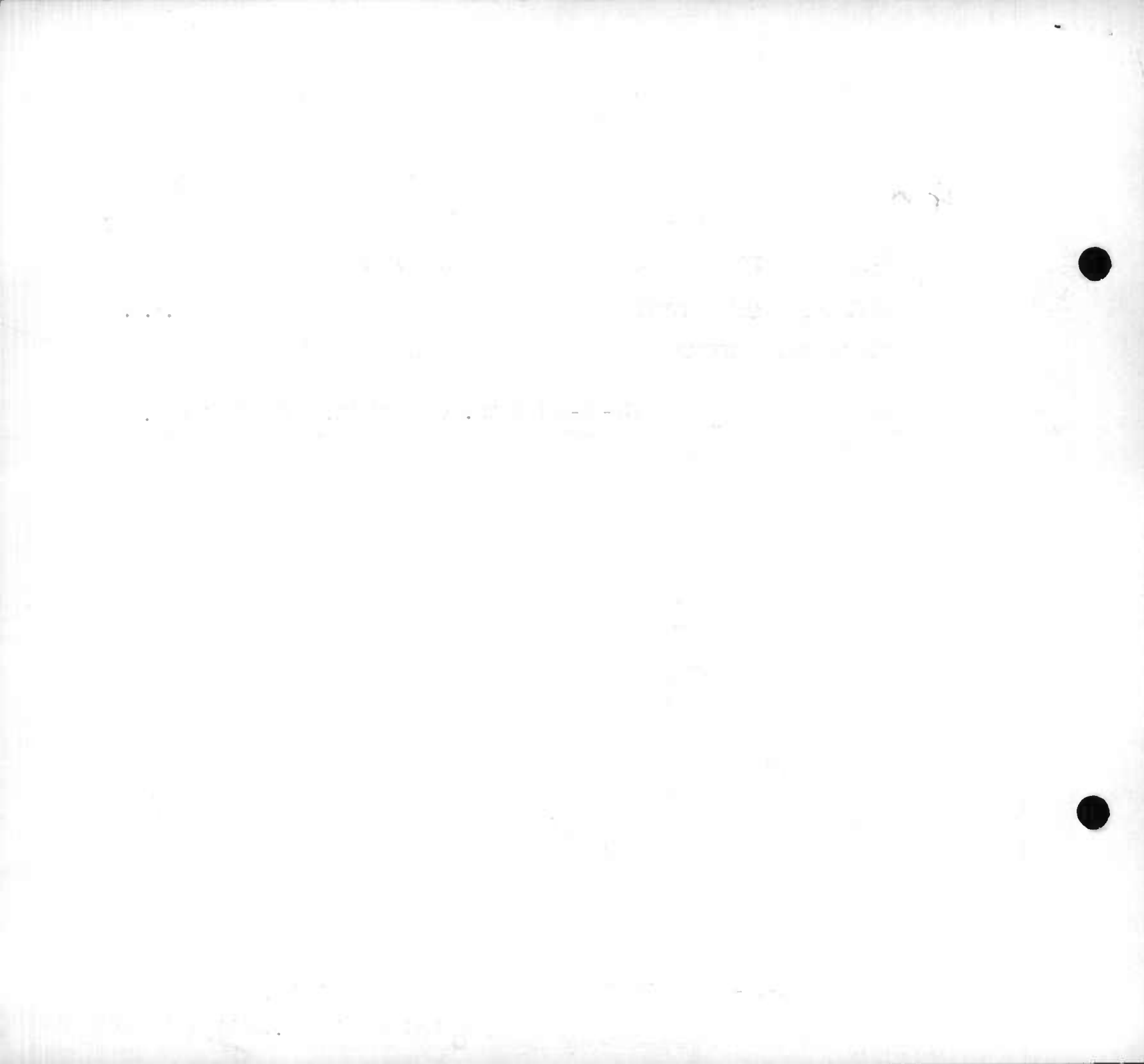
BIRTH NO. 70 00679				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00679	
1. NAME OF DECEASED (Type or Print) <b>CHARLES WILLIAMS</b>				2. DATE AND HOUR OF DEATH <b>Jan 15th, 1970 - 8:10 AM. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>624 MILITARY AVE 5300</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/04</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>CARROLL WILLIAMS</b>			14. MOTHER'S MAIDEN NAME <b>ABBIE BOOKER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARGARET HICKMAN - CHESTERTOWN MD.</b>		
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1. G.I. bleeding -&gt; 1/5/70</b> (B) <b>subterminal hematoma -&gt; 12/28/69</b> (C) <b>prolonged - C.V.A.</b> <b>subterminal hematoma</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>12/30/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>terminal hematoma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 28, 1969</b> to <b>Jan. 15, 1970</b> that (I) (we) last saw the deceased alive on <b>Jan 15th, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>Jan. 15th, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>?</b>	
23D. ADDRESS <b>SINAI HOSPITAL - BALTIMORE</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>JAN. 18</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CHURCH HILL</b>		24D. LOCATION <b>CHURCH HILL MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>	
25A. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25B. FUNERAL DIRECTOR <b>Oliver R. Hane - CHURCH HILL MD.</b>		25C. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

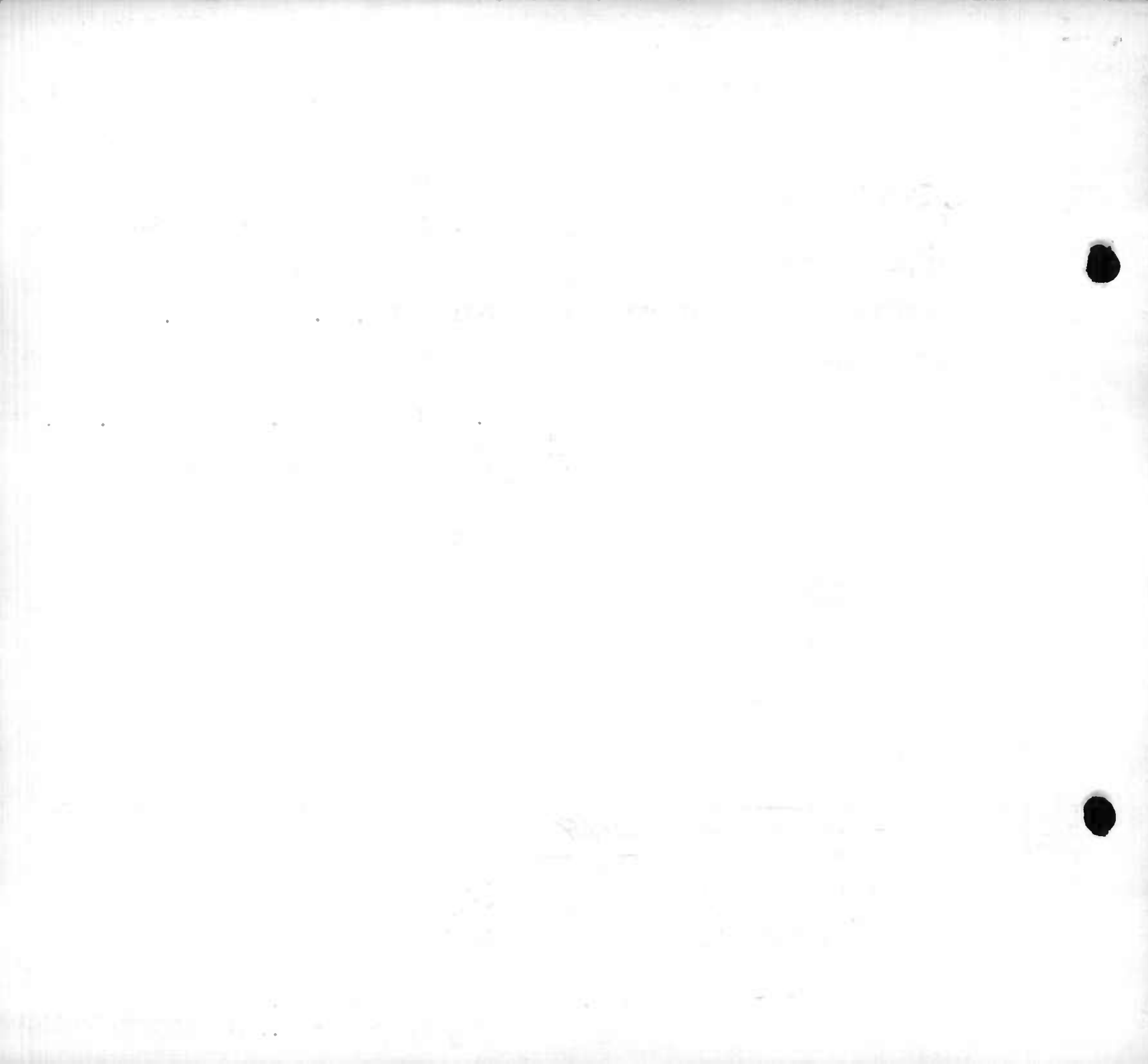
BALTIMORE CITY HEALTH DEPARTMENT				70 00680		REG. NO. 70 00680	
BIRTH NO. 70 00680				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PHILIP HOFFMAN</b>				2. DATE AND HOUR OF DEATH <b>11/17/70 1205 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Md.</b> B. COUNTY			
				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4720 Park Heights</b>		<b>2121 2716</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>XXXXXX/XX/XX</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XXXXXXX SALES</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>ROUTE</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>SAMUEL JACOB HOFFMAN</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-03-3510A</b>		17. INFORMANT <b>MRS. LEA LMINDEL, 3830 KILBURN RD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>569.9 I</b> <b>CAUSE OF DEATH</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>emphysema</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>11/16/70</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/16/70</b> to <b>11/17/70</b> 19____ that (I) (we) last saw the deceased alive on <b>11/17/70</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>11/17/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>RAFAEL LEVITES</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-18-70</b>		24C. NAME of CEMETERY or CREMATORY <b>ADATH JESHURUN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		25D. ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00681		REG. NO. 70 00681	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNA GLASSNER				1-15-70 17 <sup>20</sup> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
90 BELVEDERE NURSING HOME				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3500 PARK HEIGHTS AVENUE #21215 1513			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			78		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			AT HOME		PHILADELPHIA, PA.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LEOPOLD ROSEN				ROSA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					MR. MITCHELL GLASSNER, 3500 PARK HIGHTS, AVE. #15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Acute Respiratory Insuff.			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Metastatic Carcinoma of Uterus Sev. years.			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from 1966 to 1/15 1970 that (I) (we) last saw the deceased alive on 1/9 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Leonard Kotz				1-15-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LEONARD KOTZ				11 SLADE AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1-18-70		BALTIMORE, HEBREW		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JAN 21 1970		Robert E. Tabor, M.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

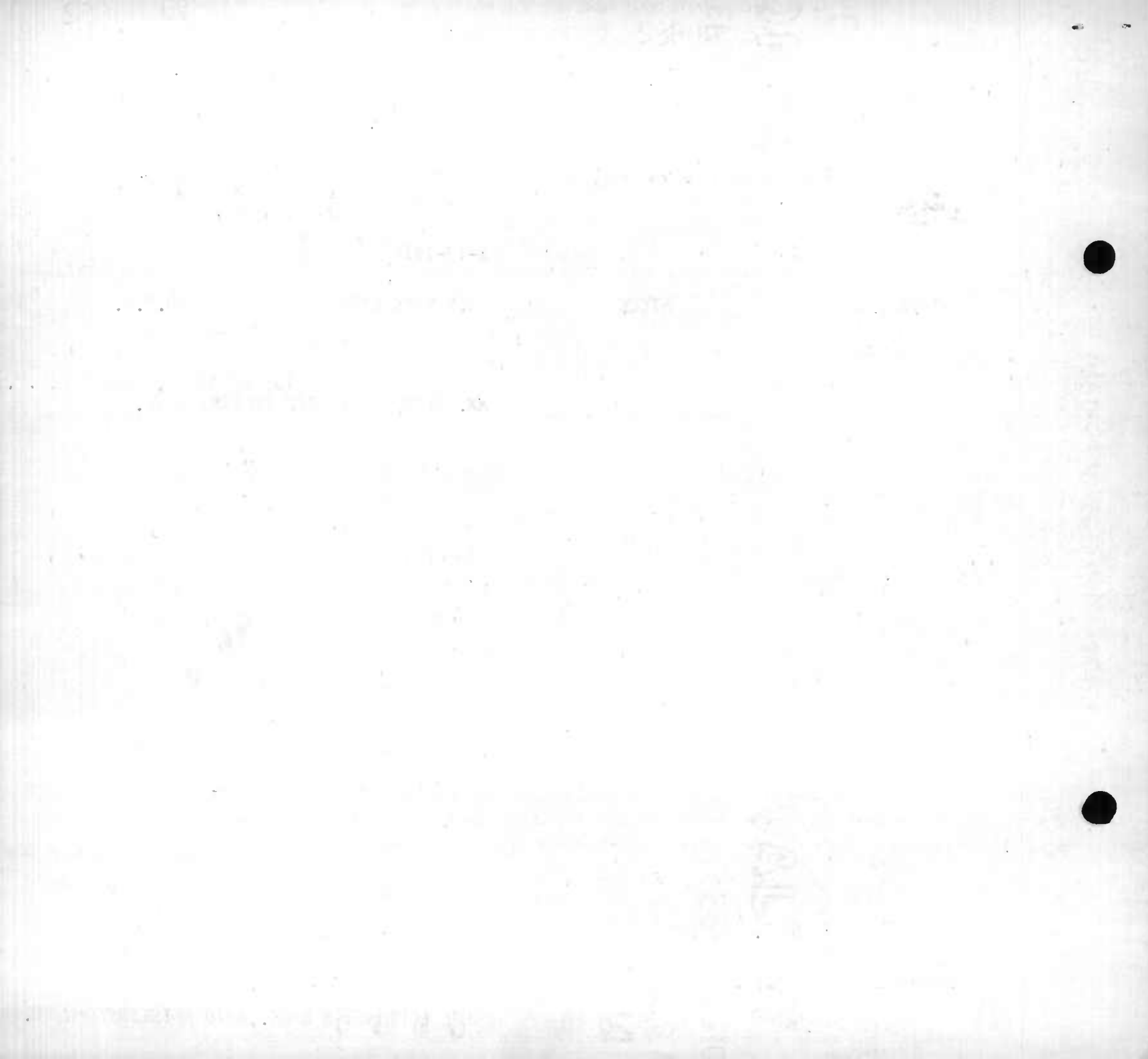




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 00682</b>
BIRTH NO. <b>70 00682</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>LEON ABRAHAM WENDROW</b>		2. DATE AND HOUR OF DEATH <b>1/16/70 3:30PM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>NEW JERSEY</b> B. COUNTY <b>BRA 3</b>		
		C. CITY OR TOWN <b>BLOOMFIELD</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <b>40 CONGER STREET AVE</b> <b>V-27</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-14-1910</b>	9. AGE (In years last birthday) <b>59</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INVESTMENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STOCK</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK CITY</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MAX WENDROW</b>		
14. MOTHER'S MAIDEN NAME <b>RACHEL LEVIN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. SEYMOUR RESNICK FUNERAL HOME,</b> ADDRESS <b>156 BROADWAY, NEW YORK, N.Y.</b>		
18. <b>1890 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>pulmonary emphysema</b> (B) <b>Plural effusion</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>metastatic renal carcinoma</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(at)</del> (this hospital) attended the deceased from <b>1-16</b> 19 <b>69</b> to <b>1-16</b> 19 <b>70</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>1/16</b> 19 <b>70</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.				
23A. SIGNATURE <b>BEN. F. HUGHES, M.D.</b>		23B. DATE SIGNED <b>1/16/70</b>		23C. PHYSICIAN'S NAME (Type) <b>BEN. F. HUGHES</b>
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>		
24B. DATE <b>1-18-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>WOODBIDGE, NEW YORK</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [unclear]</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD.</b>



E-260

70 00683

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

70 00683

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GOLDIE EICKER

2. DATE AND HOUR OF DEATH

JAN. 16, 1970 1:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SINAI HOSP. OF BALTO.

42

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1 QUIMPER CT., BRITTANEY APTS. #8 5300

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

60

11 Under 1 Yr. 11 Under 24 Hrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BENJAMIN LOUIS KIRSON

14. MOTHER'S MAIDEN NAME

EMMA GLASSER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

BRITTANEY APTS. ADDRESS

MR. HERBERT EICKER, 1 QUIMPER CT. #8

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

CEREBROVASCULAR ACCIDENT

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

POLYCYTHEMIA

(B) DUE TO, OR AS A CONSEQUENCE OF:

CHRONIC OBSTRUCTIVE LUNG DISEASE yrs.

(C)

INTERATRIAL SEPTAL DEFECT

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 day

yrs.

53 yrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 15 1970 to JAN 16 1970  
that (I) (we) last saw the deceased alive on JAN 16 1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Corisio B. Gamm, Jr. M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/16/70

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

1-18-70

24C. NAME OF CEMETERY OR CREMATORY

BETH TFILOH

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1970

25B. NAME OF REGISTRAR

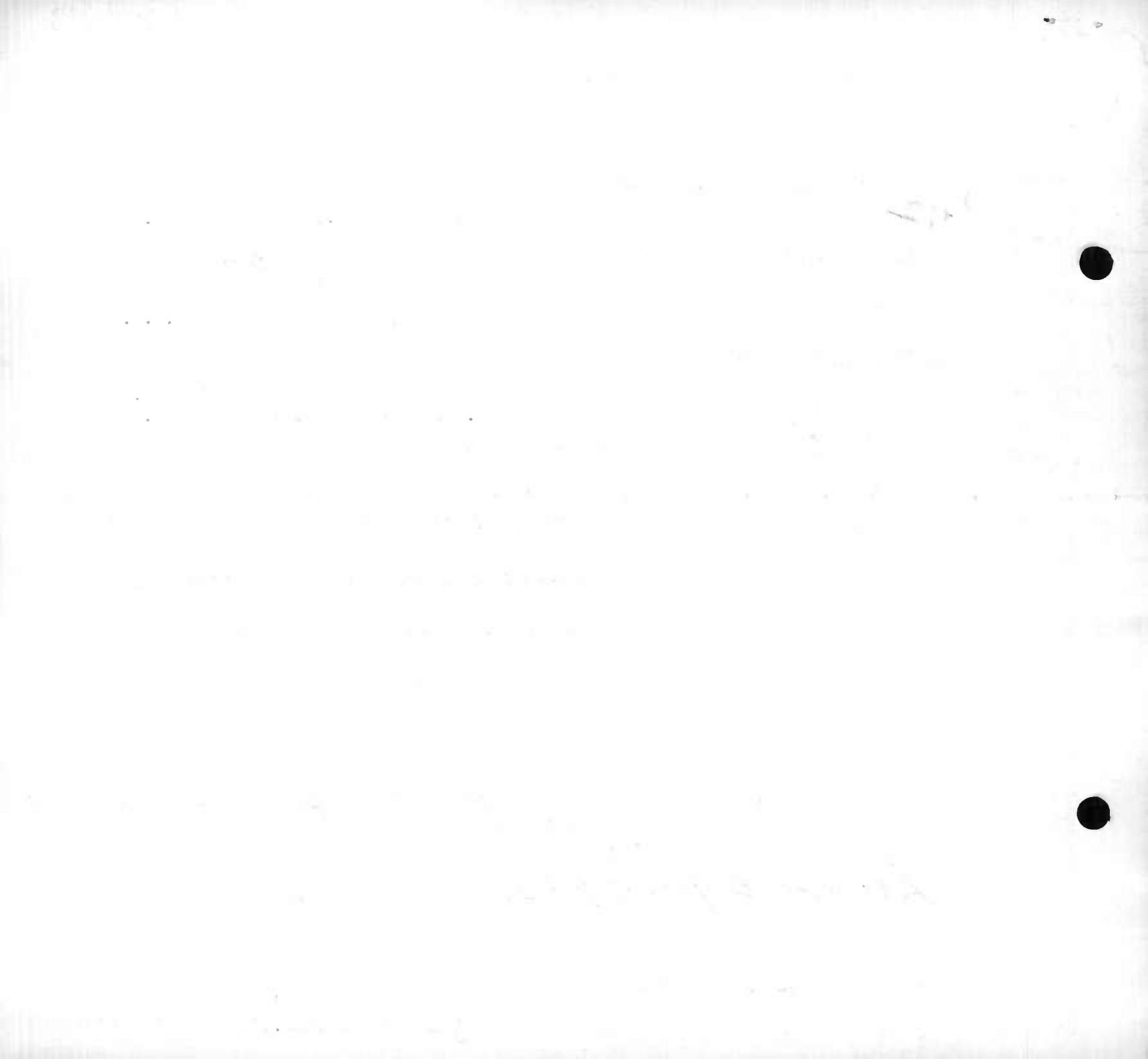
R. E. F. B. D. D. D.

25C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD

FUNERAL DIRECTOR: IMPORTANT

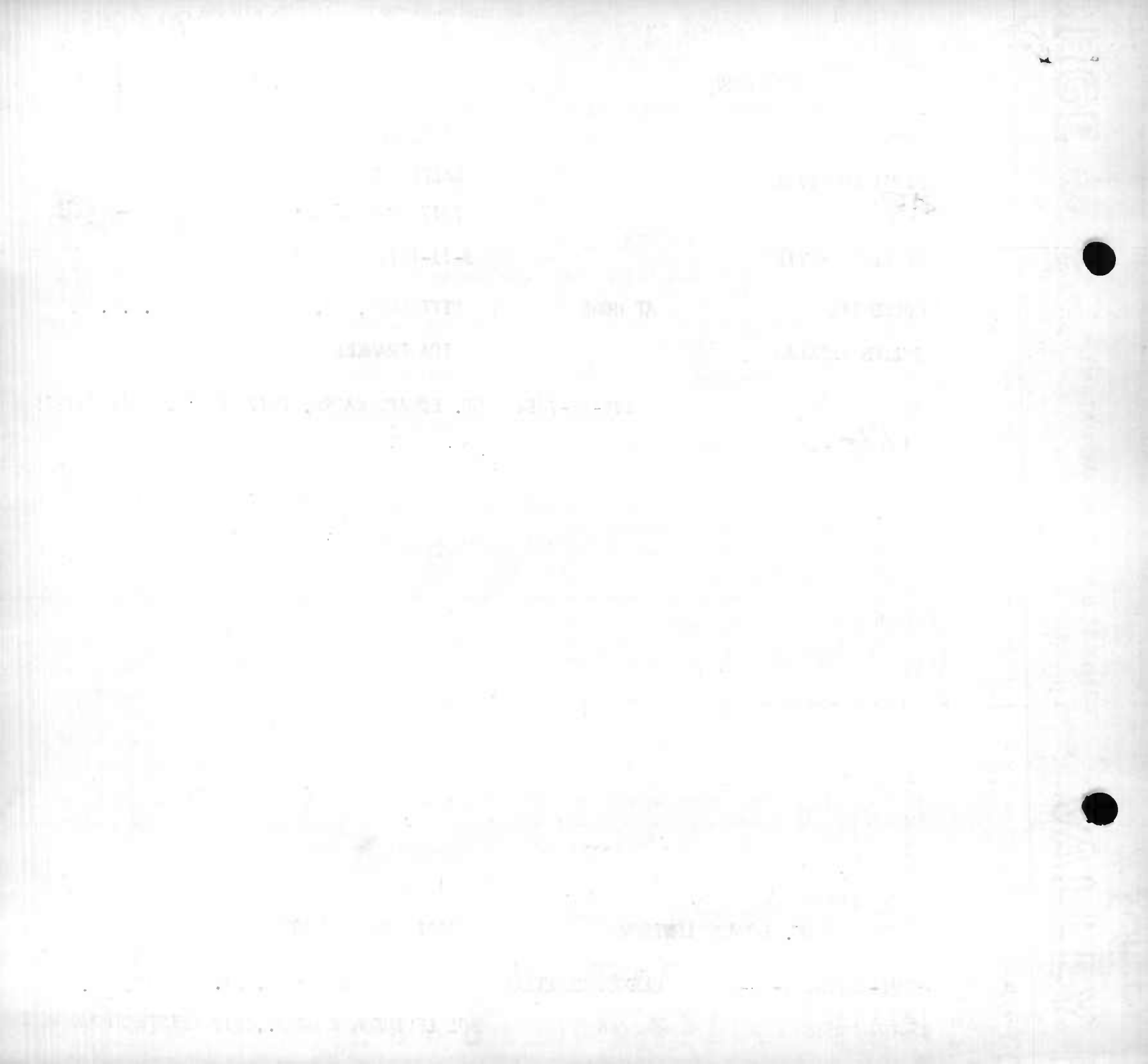
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 00684</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 00684</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARY KARSH</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JANUARY 16, 1970</span> <span style="font-size: 1.5em;">6:15 P</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">SINAI HOSPITAL</span> <span style="font-size: 1.5em;">42</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <span style="font-size: 1.2em;">7017 BOXFORD ROAD</span> <span style="font-size: 1.5em;">27-30</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3-13-1917</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">52</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">AT HOME</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PITTSBURG, PA.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">JULIUS BERKMAN</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">IDA FRANKEL</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">209-09-7454</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MR. EDWARD KARSH, 7017 BOXFORD ROAD #21215</span>			
18. CAUSE OF DEATH					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Metastatic Breast Cancer</span>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Extensive Lung Metastases</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">2-3 years</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.5em;">Secondary to Breast Cancer</span>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Dec.</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">Jan</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Jan.</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Dr. Edward J. Levinson</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">1-17-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DR. EDWARD LEVINSON</span>				23D. ADDRESS <span style="font-size: 1.2em;">7501 PARK HEIGHTS AVENUE</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">REMOVAL-BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">1-18-70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">TIPHERETH ISRAEL HEBREW CEMETERY</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">MELVILLE, PA.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 21 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Barry E. Taylor, D.O.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00685

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

70 00685

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JACOB ROSOFSKY

2. DATE AND HOUR OF DEATH

JANUARY 16, 1970

1:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PALL MALL NURSING HOME

90

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

4601 PALL MALL ROAD #21215

2716

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

MARCH 15, 1878

9. AGE (In years last birthday)

91

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

RETAIL MERCHANT

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MANOCHA ROSOFSKY

14. MOTHER'S MAIDEN NAME

ELKA

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-32-2784

17. INFORMANT

ADDRESS

MRS. GERTRUDE PACKER, 7502 LABYRINTH RD. #8

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic CV. disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 13 1966 to Jan 16 1970 that (I) (we) last saw the deceased alive on Jan 16 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Nathan Needle

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Jan 17, 1970

23C. PHYSICIAN'S NAME (Type)

NATHAN NEEDLE

23D. ADDRESS

6506 Park Heights Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)  
BURIAL

24B. DATE

1-18-70

24C. NAME OF CEMETERY or CREMATORY

MARYLAND LODGE

24D. LOCATION

(City, town, or county)

ROSEDALE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

SOI LEVINSON

ADDRESS

38 BROS. 6010 REISTERSTOWN RD.

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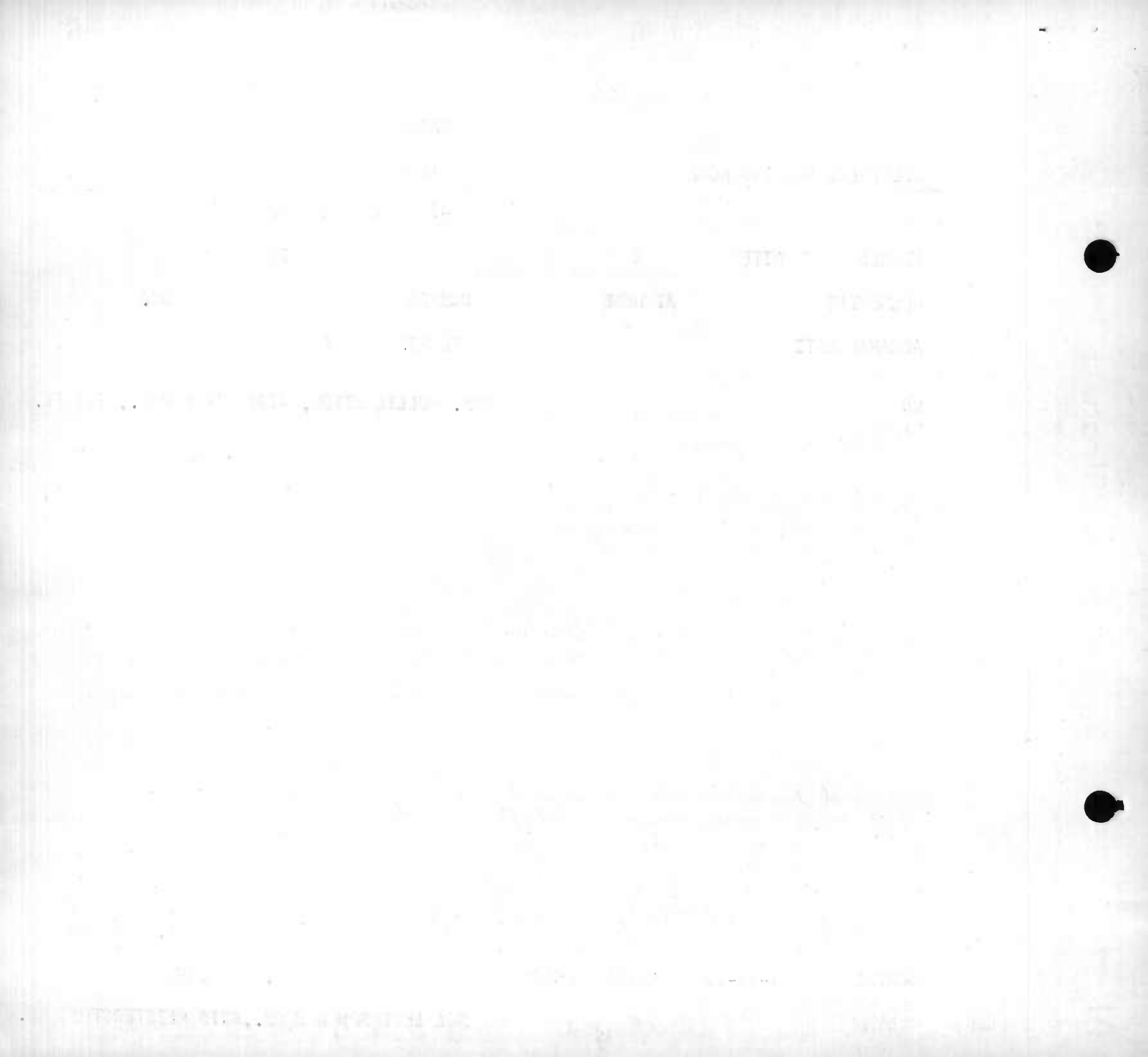
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00686</u>
BIRTH NO. <u>70 00686</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Tessie Katz</u>		2. DATE AND HOUR OF DEATH <u>1/16/70</u> <u>6 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>BELVEDERE NURSING HOME</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4100 MAINE AVENUE</u> <u>1510</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>75</u>	9. AGE (In years last birthday) <u>75</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ABRAHAM KATZ</u>		
14. MOTHER'S MAIDEN NAME <u>TESSIE ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <u>MRS. MOLLIE WITOW, 4100 MAINE AVE., 1st FL.</u>		
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>Cerebral vascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>		
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED _____ While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (1) (this hospital) attended the deceased from <u>Jan 1962</u> to <u>Jan 16 1970</u> , that (1) (we) last saw the deceased alive on <u>Jan 16 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert E. Levy</u>		23B. DATE SIGNED <u>1/17/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert E. Levy</u>
23D. PHYSICIAN'S NAME (Type) <u>Robert E. Levy</u>		23E. ADDRESS <u>114 Medical Arts Bldg</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-18-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>AHAVAS SHALOM</u>
24D. LOCATION <u>ROSEDALE, MARYLAND</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		
24F. NAME OF REGISTRAR <u>Robert E. Levy</u>		24G. FUNERAL DIRECTOR ADDRESS <u>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00687	
BIRTH NO. 70 00687		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lillian Weinberg		2. DATE AND HOUR OF DEATH 1/17/70 10:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore Inc.		A. STATE Md.		B. COUNTY Baltimore	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6400 ELRAY DRIVE		F. ZIP CODE 21206	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/09	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAAC NEWMAN		14. MOTHER'S MAIDEN NAME MINNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-01-7652		17. INFORMANT MRS. JESSE WEINBERG Dr. Carlos R. Perel 6400 ELRAY DR.	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: ASCVD. (B) DUE TO, OR AS A CONSEQUENCE OF: Arterial Hypertension (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1:20 PM 1/17 1970 to 10:15 PM 1-17 1970 that (I) (we) last saw the deceased alive on 1-17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chief		23B. DATE SIGNED 1/17/70		23C. PHYSICIAN'S NAME (Type) Carlos R. Perel	
23D. ADDRESS Sinai Hospital of Baltimore		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-19-70		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. LOCATION (State)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	

10/10/1910

10/10/1910

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ISRAEL <del>ISRAEL</del> GORDON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2204 E. Lombard St.</b>		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour <b>12:30 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b>		B. COUNTY					
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-15-1894</b>	10. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>2204 E. Lombard St.</b>			
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GERSHON GORDON</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-CLOTHING</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>SEWING FACTORY</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>MRS. BENJAMIN FRANKLE, 3909 BANCROFT RD. #15</b>			
19. <b>412.41</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>1-19-70</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>TZEMECH ZEDEK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>	

7

1-12-1964  
J. W. A.  
GENERAL MANAGER  
UNION

RECEIVED  
1-12-1964

RECEIVED

VALLEY PARK

ADDITIONAL

RECEIVED

1-12-1964

1-12-1964

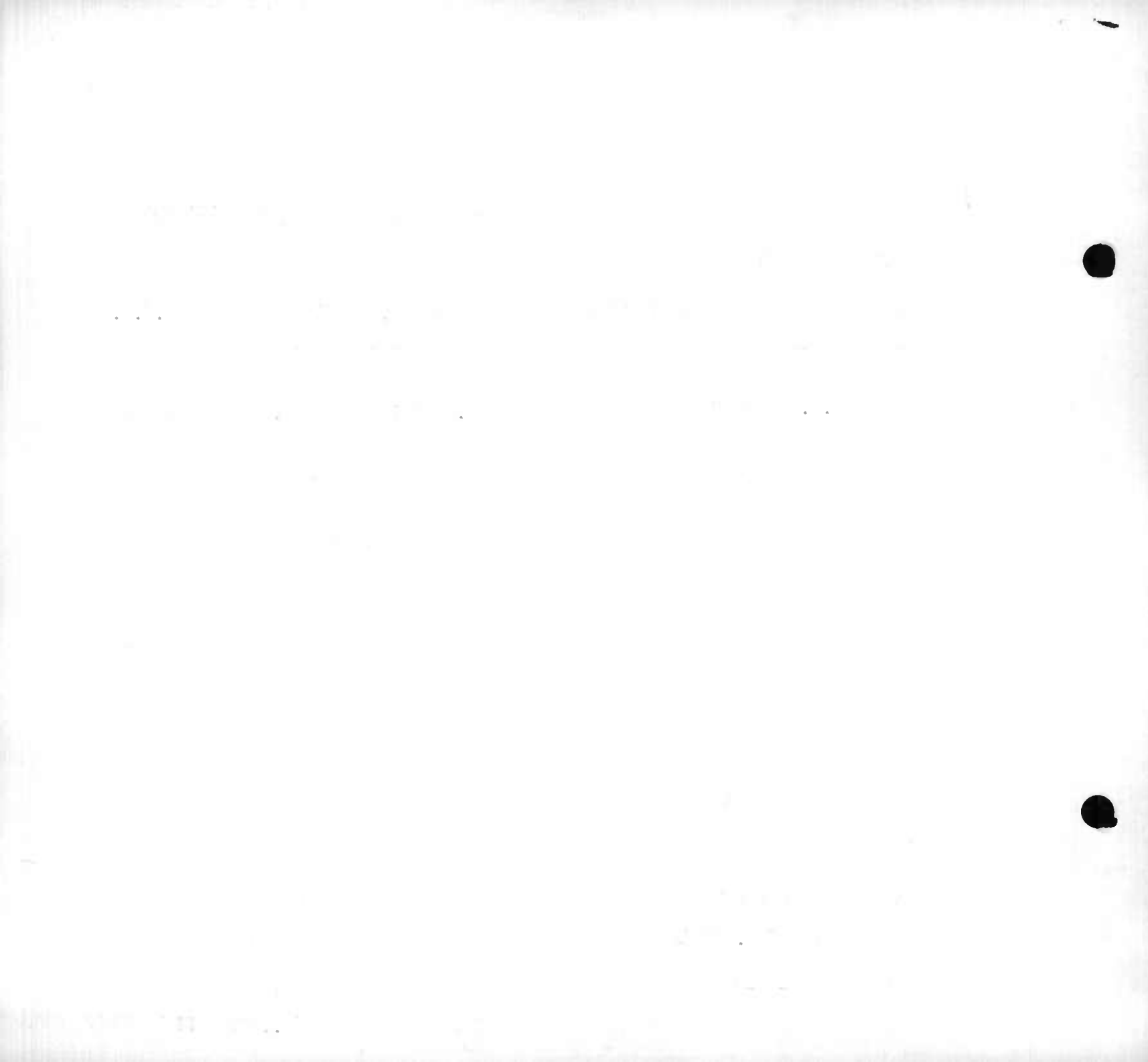
1-12-1964

FOR RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00689		REG. NO. 70 00689	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Julius Schwartz</u>				2. DATE AND HOUR OF DEATH <u>1/18/70</u> <u>845</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Levinthal Hebrew Home + Infirmary</u>				A. STATE <u>MD</u> B. COUNTY <u>Balto</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-15-XX 13</u>		9. AGE (In years last birthday) <u>XX 56</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>PARKING LOT</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>WOLFE SCHWARTZ</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE ?</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. II ARMY</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS. ESTHER SCHWARTZ, 6929 FIELDCREST ROAD</u>				ADDRESS			
18. <u>450 X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pul Embolus</u>				<u>minutes</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) <u>None</u>				DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>None</u>				DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Multiple Sclerosis</u>				<u>years</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>7/20</u> 19 <u>67</u> to <u>1/18</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>1/18</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ellis S. Caplan</u>				23B. DATE SIGNED <u>1/18/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ELLIS S. CAPLAN</u>	
23D. ADDRESS <u>Sinai Hospital</u>				23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-20-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>JOSE E. PABLO, MD.</u>		25C. FUNERAL DIRECTOR <u>SQL LEVINSON &amp; BROS., 6010 REESTERTOWN ROAD</u>		25D. ADDRESS	

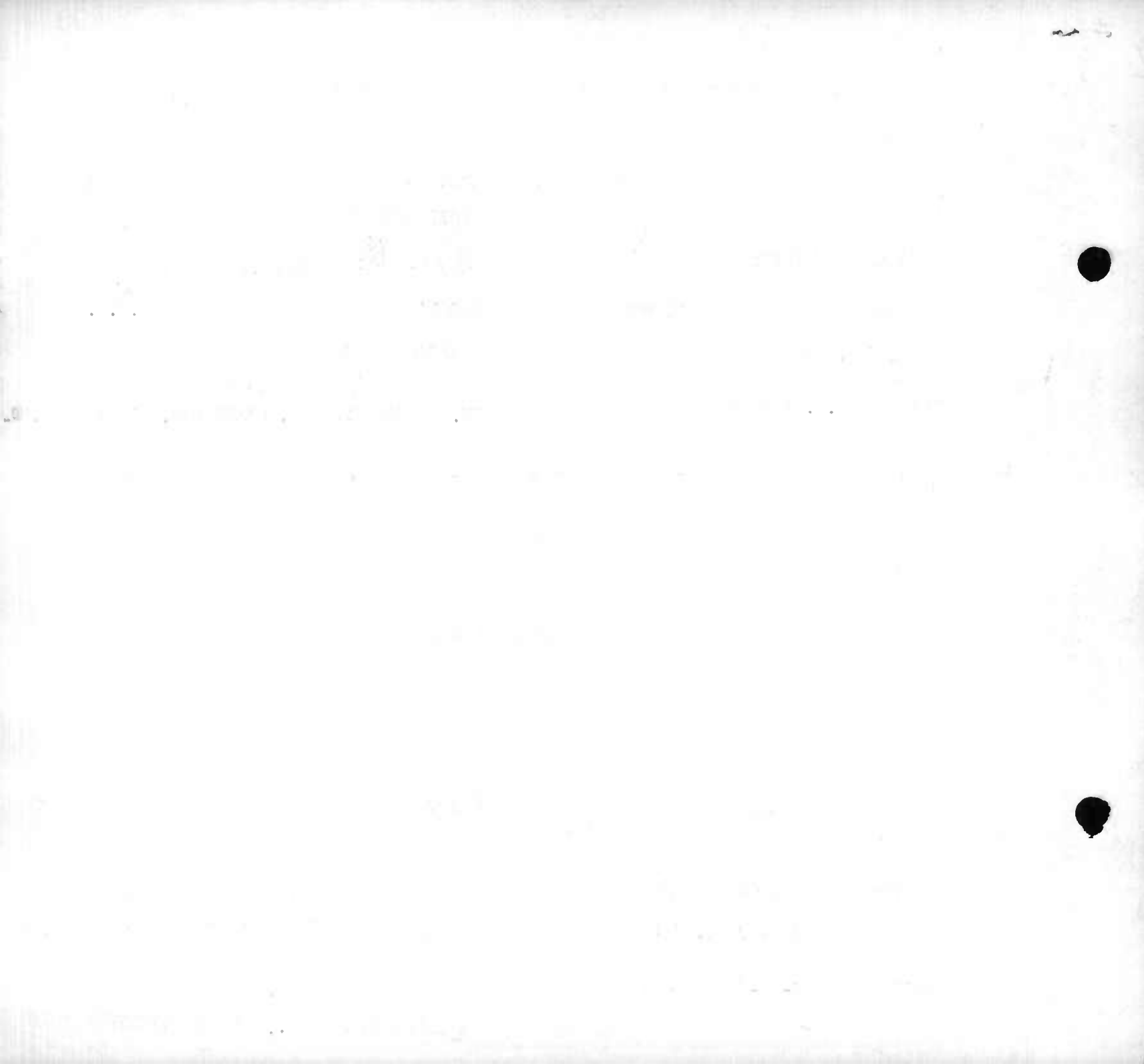




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

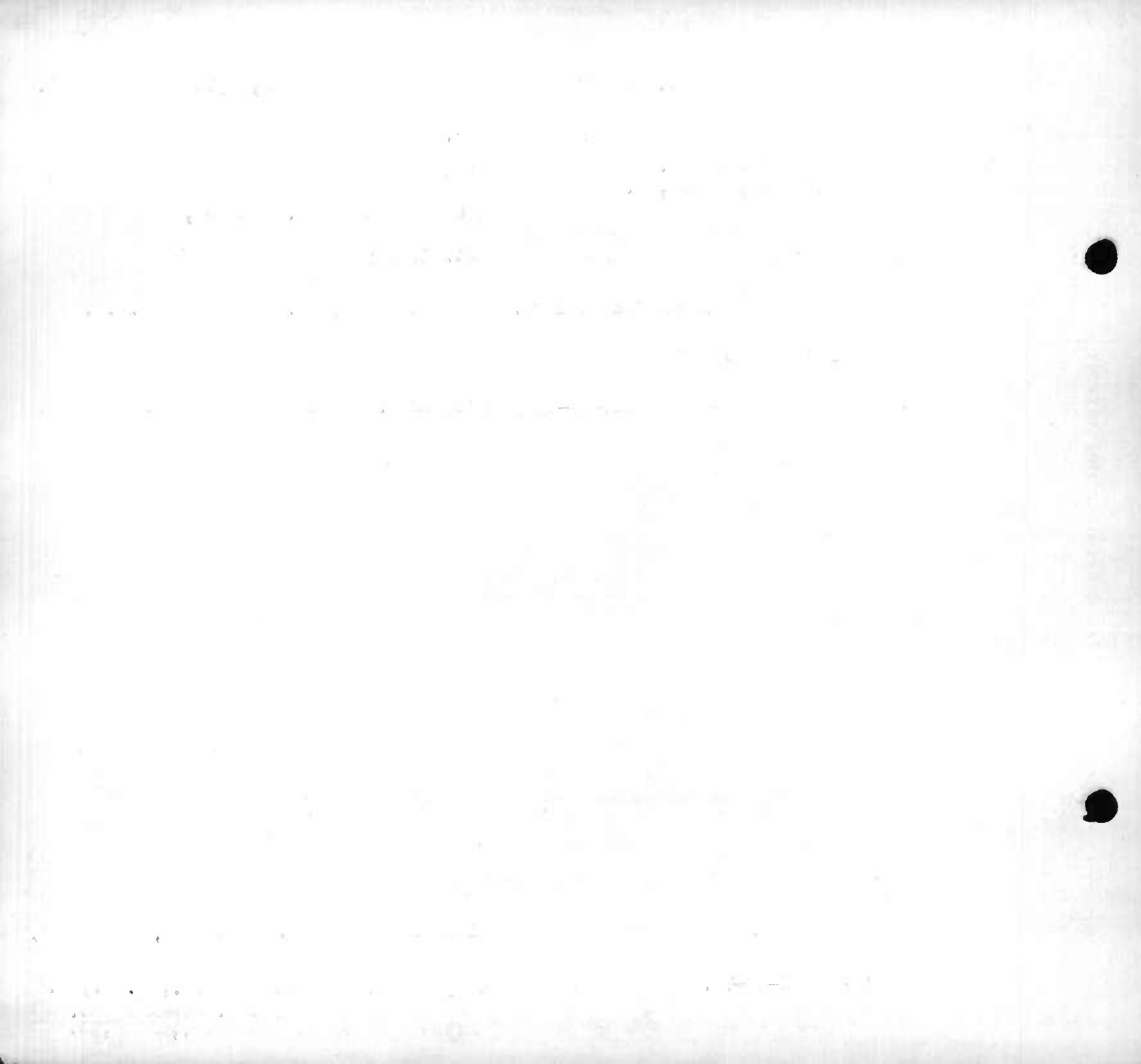
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00690</span>	
70 00690				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LITT MAN - ABRAHAM</b>		2. DATE AND HOUR OF DEATH <b>1/19/70 7:55 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Baltimore - Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai hospital of Baltimore</b>		C. CITY OR TOWN <b>Randallstown</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>8611 WOODSPRING ROAD 5300</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/24</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PLUMBER</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LEON LITTMAN</b>			
14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. I ARMY</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. HANNAH LITTMAN, 8611 WOODSPRING ROAD RANDALLSTOWN, MD.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>complete heart block.</b>		<b>on 6 Hours</b>	
2. ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>coronary insufficiency - aortic MI</b>		<b>2 1/2 Hours</b>	
3. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I A.		<b>ASCARD.</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/19</b> 19 <b>70</b> to <b>1/19</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/19</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hoorajar 9068. M.D.</b>				23B. DATE SIGNED <b>1/19/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. HOORAZAR</b>				23D. ADDRESS <b>Sinai hospital - Baltimore MD. 21215</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH JACOB</b>	
24D. LOCATION (City, town, or county) (State) <b>FINKSBURG, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>			
25B. NAME OF REGISTRAR <b>R. E. J. B. M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00691</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES J. NEMEC		January 17, 1970 2:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4800 Hamilton Ave. Baltimore, 21206, Md.			A. STATE Md.		
			B. COUNTY		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 4800 Hamilton Ave. # 21206, 2C 31		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 21, 1905	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Baugb Chemical Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Nemeo			14. MOTHER'S MAIDEN NAME Mary Kafka		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-8343	17. INFORMANT Mildred I. Nemeo		ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma Head of Pancreas</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>asthma</i>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 19 69 to 1-17 19 70, that (I) <del>was</del> lost saw the deceased alive on 1-17 19 70 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley B. Klijanowicz</i> DEGREE				23B. DATE SIGNED 1-19-70	
23C. PHYSICIAN'S NAME (Type) STANLEY B. KLIJANOWICZ				23D. ADDRESS 8121 Loch Raven Rd. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-20-70.		Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State)		7225 Eastern Blvd., Ba. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR: ADDRESS	
JAN 21 1970		Robert E. Taylor, M.D.		901 S. Conkling St. Baltimore, 21224, Md.	



R-500

## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00692	
CERTIFICATE OF DEATH					
BIRTH NO. 69-32011		70 00692			
1. NAME OF DECEASED (Type or Print) <u>SUSAN JOY RAMEY</u>			2. DATE AND HOUR OF DEATH <u>JAN 15 1970 6 08 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITAL</u> <u>4940 Eastern Avenue, Balto., Md. 21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>F</u>			6. RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>11/27/69</u>	
13. FATHER'S NAME <u>RUEL B. Ramey</u>		14. MOTHER'S MAIDEN NAME <u>Betty Lovely</u>		9. AGE (In years last birthday) <u>1 19</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
17. INFORMANT <u>BCH Records - Baltimore, Maryland 21224</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Heart disease - CRIB DEATH</u> IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>multiple defects</u>	
19. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>JAN 15 1970</u> to <u>JAN 15 1970</u> that (1) (we) last saw the deceased alive on <u>JAN 15 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard M. Thaler MD</u>			23B. DATE SIGNED <u>1/15/70</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD M THALER MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/17/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>			25B. NAME OF REGISTRAR <u>John J. Puda</u>		25C. FUNERAL DIRECTOR <u>7922 Wise Ave. Dundalk, Md. 21222</u>



70 00693

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mike Budash, Sr.

2. DATE AND HOUR OF DEATH

1/18/70

6:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7847 St. Gregory Drive 21222

5300

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

12-28-81

9. AGE (In years  
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Coal Miner

10B. KIND OF BUSINESS OR INDUSTRY

Reading Coal Co.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mike Budash

14. MOTHER'S MAIDEN NAME

Anna ?

15. Was Deceased Ever In U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

210-03-4832

17. INFORMANT

ADDRESS

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) SEVERE CHRONIC LUNG DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

(C) ASCVD

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/15 19 70 to 1/18 19 70  
that (I) (we) last saw the deceased alive on 1/17 19 70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

JACK McCue M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/18/70

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/21/70

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 21 1970

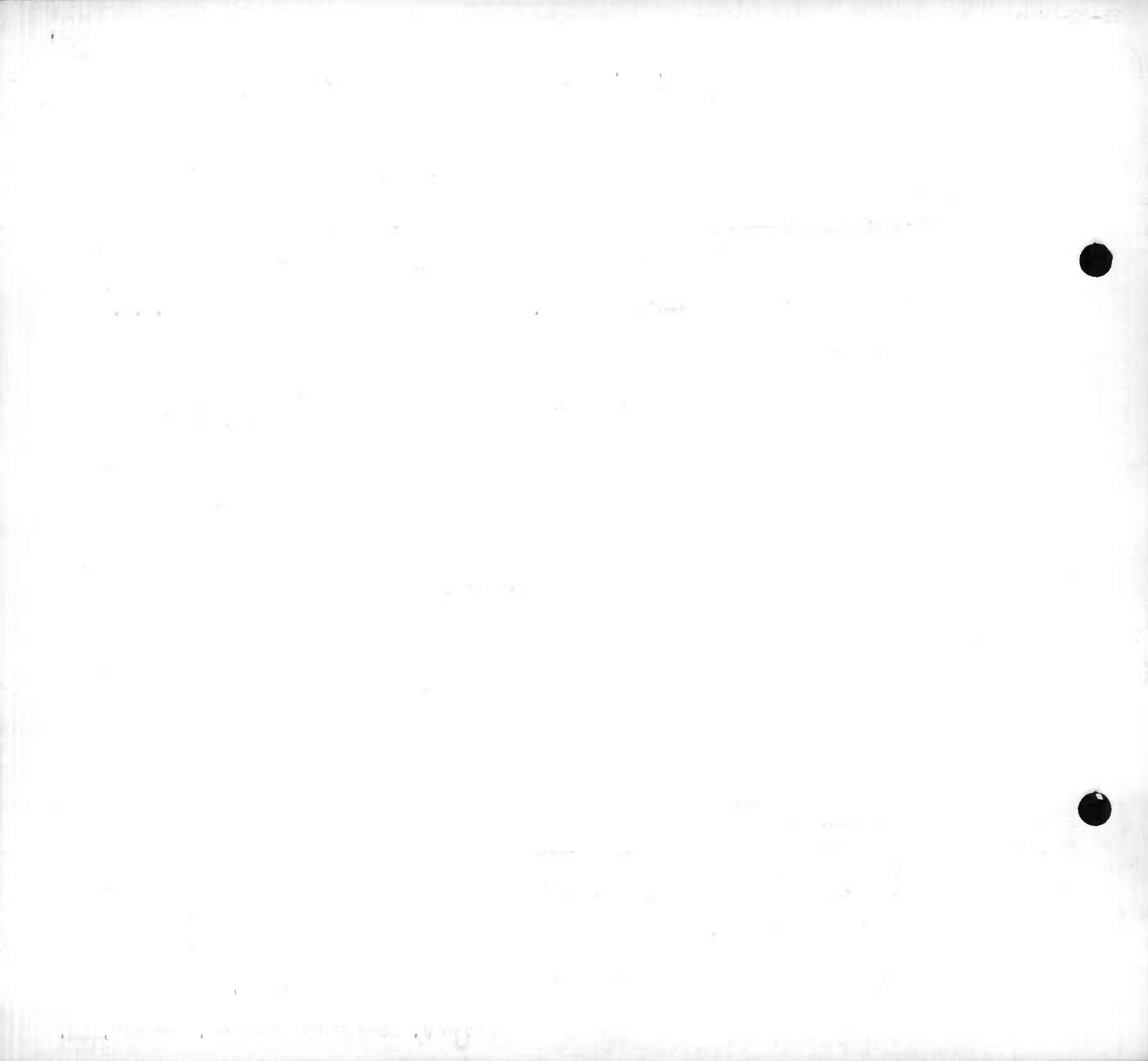
R. E. F. B. &amp; S.

John J. Duda 7922 Wise Ave. Dundalk, Md.

21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

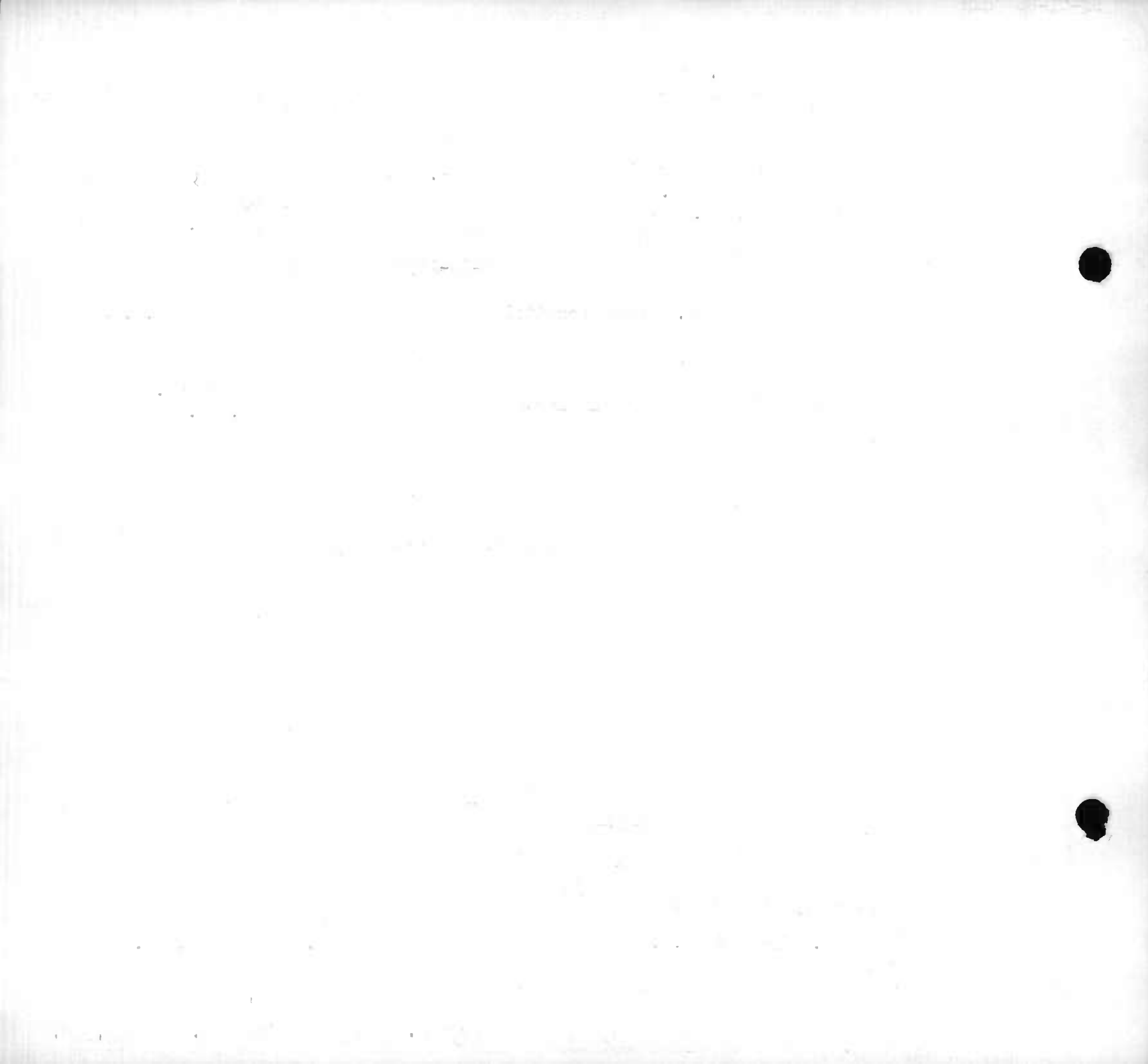




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00694</span>
BIRTH NO. <span style="float: right;">70 00694</span>				
1. NAME OF DECEASED (Type or Print) <b>Jesse A. Capps</b>		2. DATE AND HOUR OF DEATH <b>1/17/70</b> <span style="float: right;">345 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>		C. CITY OR TOWN <b>Ft. Howard</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2-10-1899</b>		9. AGE (In years last birthday) <b>70</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard &amp; Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ft. Howard Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Capps</b>		
14. MOTHER'S MAIDEN NAME <b>Joan ??</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wpr or dates of service) <b>Yes Army WW I</b>		
16. SOCIAL SECURITY NO. <b>213-07-7050</b>		17. INFORMANT <b>BCH Records: Baltimore, Md. 21224</b>		
18. <b>61.8</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Spontaneous Cardiac Arrest Nov 68.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8-16</b> <b>19 69</b> to <b>1-17</b> <b>19 70</b> that (I) (we) last saw the deceased alive on <b>1-17-70</b> <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>J. Wisneski</b> M.D.				23B. DATE SIGNED <b>1-17-70</b>
23C. PHYSICIAN'S NAME (Type) <b>J. Wisneski</b>				23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		
25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		
25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MONROE WALKER

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

January 17, 1970

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 17, 1970

6:28 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

6. SEX

7. RACE

8. MARRIED ☐NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

Negro

WIDOWED ☐DIVORCED ☐

Baltimore

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

576 St. Mary's Street

1701

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U

13. FATHER'S NAME

?

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

WAS

W W I

17. SOCIAL  
SECURITY NO.

220-03-1937

18. INFORMANT

ADDRESS

MRS FAYE COOPER, SAME

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 18, 1970

24A. BURIAL CREMATION,  
REMOVAL, (Specify)

Burial

24B. DATE

1/22/70

24C. NAME OF CEMETERY or CREMATORY

National Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W

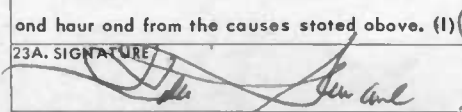
ADDRESS

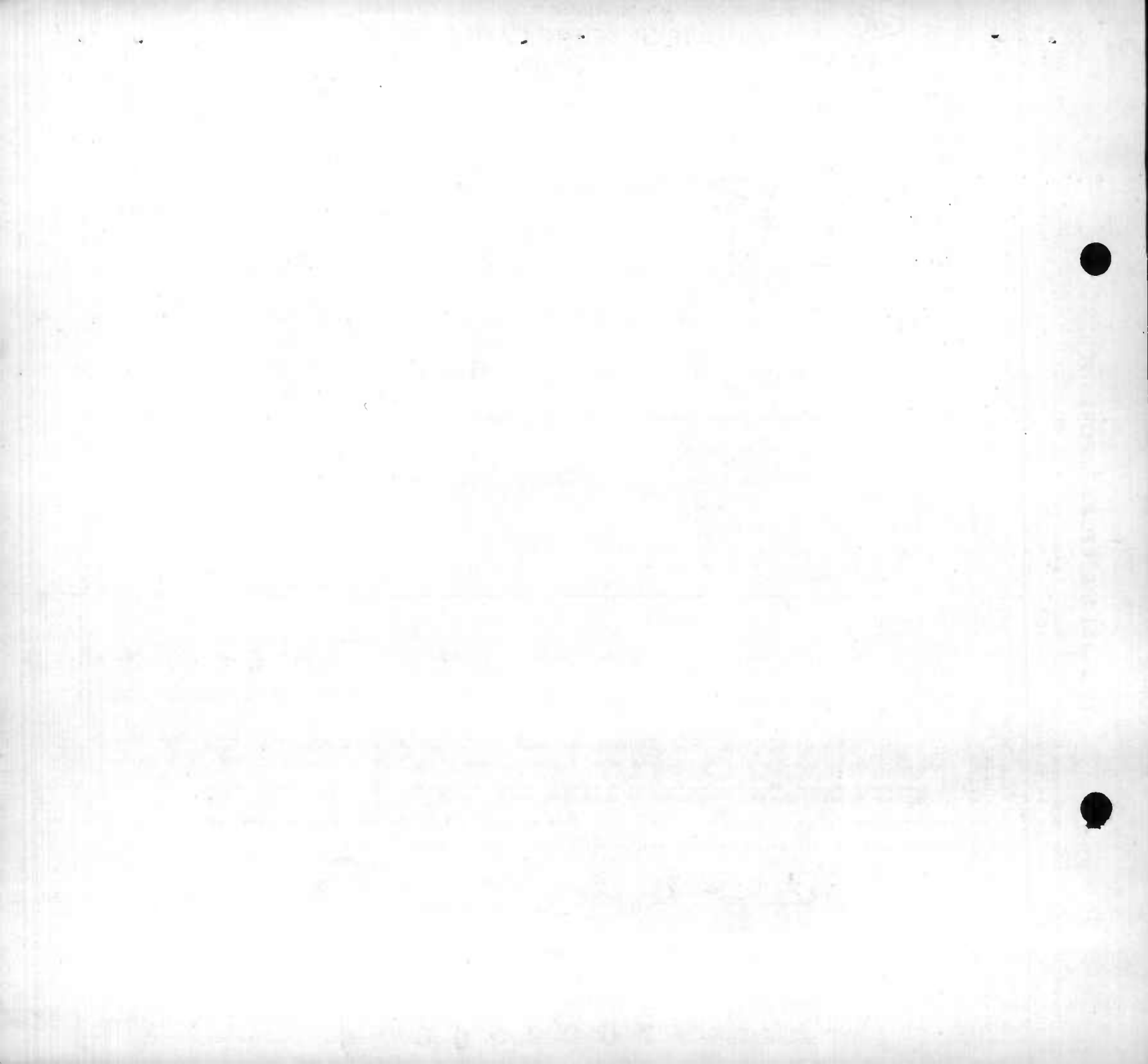
North Ave

ALC. ADHEMITY BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00696
BIRTH NO. 70 00696		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>JOSEPH E. Smith</b>		2. DATE AND HOUR OF DEATH <b>1/17/70</b> <b>1:45 PM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lincoln Memorial Home</b> <b>27 N. CAREY ST.</b> <b>BALTIMORE, MARYLAND</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/4/199</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>187-26-3180A</b>		17. INFORMANT <b>Chart,</b>
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p style="text-align: center;">I</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;"><b>Pneumonia</b></p> <p style="text-align: center;">(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">(C) DUE TO, OR AS A CONSEQUENCE OF:</p>				
<p style="text-align: center;">II</p> <p style="text-align: center;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12/5/69</b> 19 <b>69</b> to <b>1/17/70</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>1/17/70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>1/17/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. E. E. Smith, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/21/70</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery Baltimore Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W north Ave</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-2001

BALTIMORE CITY HEALTH DEPARTMENT				70 00697		CERTIFICATE OF DEATH		REG. NO. 70 00697	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>HESS, CORA B.</b>		2. DATE AND HOUR OF DEATH <b>1-17-70 1:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL 44</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>4709 PILGRIM ROAD 2733</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-17-00</b>	9. AGE (in years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BISCOE</b>				14. MOTHER'S MAIDEN NAME <b>MARY TRICE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>237-407-4542</b>		17. INFORMANT <b>DAUGHTER</b>		ADDRESS <b>MRS. ETHEL BOSLEY 1436 PROVIDENCE RD, BALTIMORE</b>	
18. <b>533.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>CHRONIC UREMIA - ANURIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ANEMIA DUE TO BLEEDING PEPTIC ULCER</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>SECOND. CONGESTIVE HEART FAILURE</b> (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<b>CHRON. ARTHRITIS</b>					
19A. DATE OF OPERATION <b>1-12-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>1-12-70</b> 19 <b>70</b> to <b>1-17</b> 19 <b>70</b> that (I) <del>was</del> lost saw the deceased alive on <b>1-17</b> 19 <b>70</b> and that (in my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) view the body after death.									
23A. SIGNATURE <b>J. P. Mikus M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-17-70</b>			
23C. PHYSICIAN'S NAME (Type) <b>J. P. MIKUS</b>				23D. ADDRESS <b>UMH.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. J. Baker M.D.</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>			

HEED 2004 3

GRACE MEMORIAL HOSPITAL  
BAPTIST CHURCH  
4709 PILGRIM ROAD

FEMALE WHITE  
E-17-CC BY

HOLLY WIFE  
MARYLAND U.S.A.

WILLIAM BIGGIE

MARY TRICE

DAUGHTER  
MAY 1901

GRACE KEMMIS - MURKIN

ARMED AND DANGEROUS  
MURKIN

RECORDS OFFICE

THREE FIVE

NO

1-17-15  
1-17-15

J. B. MURKIN

1-17-15



FUNERAL DIRECTOR: IMPORTANT

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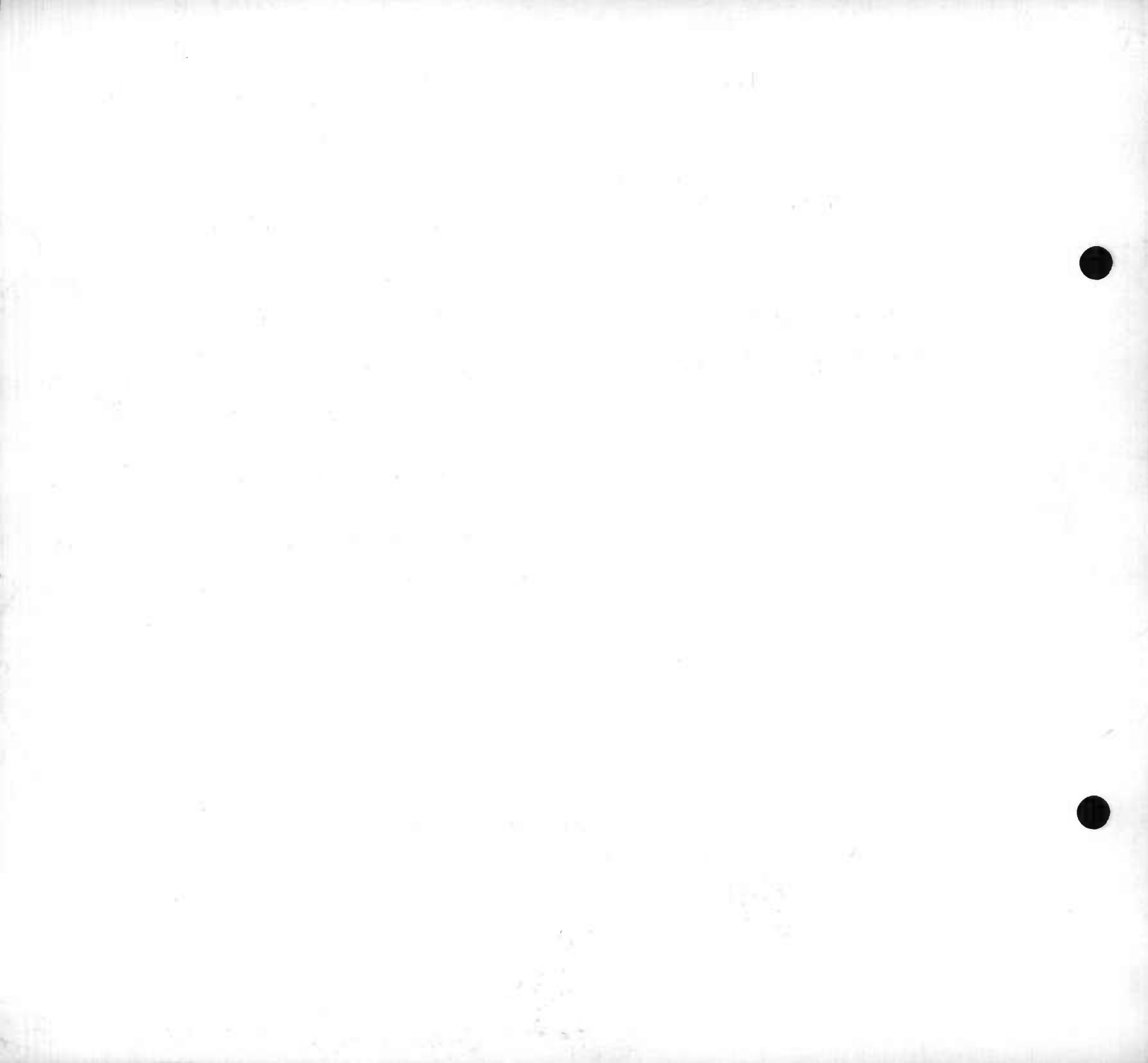
BALTIMORE CITY HEALTH DEPARTMENT									
70 00698					CERTIFICATE OF DEATH		REG. NO. 70 00698		
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>WILLIAM HUGGINS.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					2. DATE AND HOUR OF DEATH <u>1.17.70</u> <u>2<sup>00</sup></u> <u>A.M.</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>601 Elmwood Rd. 5300</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/98</u>	9. AGE (In years last birthday) <u>71</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10B. KIND OF BUSINESS OR INDUSTRY <u>Ins. salesman</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Huggins.</u>					14. MOTHER'S MAIDEN NAME <u>Ozzyms. Katherine</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>215-10-9782</u>				
					17. INFORMANT <u>Mrs Helen L. Huggins</u> ADDRESS <u>601 Elmwood Road</u>				
18. <u>560.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Probable recurrent pulmonary embolus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u>					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Embolus</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post op transverse colectomy 15d.</u>					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Torsion midgut with strangulation transverse 15d.</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					(C) <u>Colon.</u>				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>1.2.70</u> 19 to <u>1.17.70</u> 19 that <u>HE</u> lost saw the deceased alive on <u>2AM 1.17</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>HE</u> (We) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>Karl F. Much, Jr. M.D.</u>					23B. DATE SIGNED <u>1.17.70.</u>			23C. PHYSICIAN'S NAME (Type) <u>Karl F. Much, Jr. M.D.</u>	
23D. ADDRESS <u>DEGREE</u>									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<u>1-20-1970</u>		<u>1-20-1970</u>		<u>Gardens of Faith</u>		<u>Fullerton Balto Md</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<u>JAN 21 1970</u>		<u>Robert E. Talley, M.D.</u>		<u>Lassahn Funeral Home</u>		<u>7401 Belair Road</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00699	
BIRTH NO. 70 00699		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SUSIE PITT		2. DATE AND HOUR OF DEATH 1/19/70 4AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL 600 N. BROADWAY		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1321 VALLEY STREET 909			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1944	9. AGE (In years last birthday) 25	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk Va.	
13. FATHER'S NAME Roland Holland		14. MOTHER'S MAIDEN NAME Dorothy Smith		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lawrence Pitt 1321 Valley St	
18. 481X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram positive Sepsis (B) Left Empyema (C) Pneumococcal pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 18 1970 to Jan 19 1970 that (I) (we) last saw the deceased alive on Jan 19 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE [Signature] MD		23B. DATE SIGNED Jan 19, 1970		23C. PHYSICIAN'S NAME (Type) F. Ruiz-Maza MD	
24A. REMOVAL CREMATION, REMOVAL (Specify)		24B. DATE 1/20/70		24C. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24D. LOCATION (City, town, or county) Norfolk		24E. LOCATION (State) Va		24F. LOCATION (Street) 1304 N. Central St	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR [Signature]	

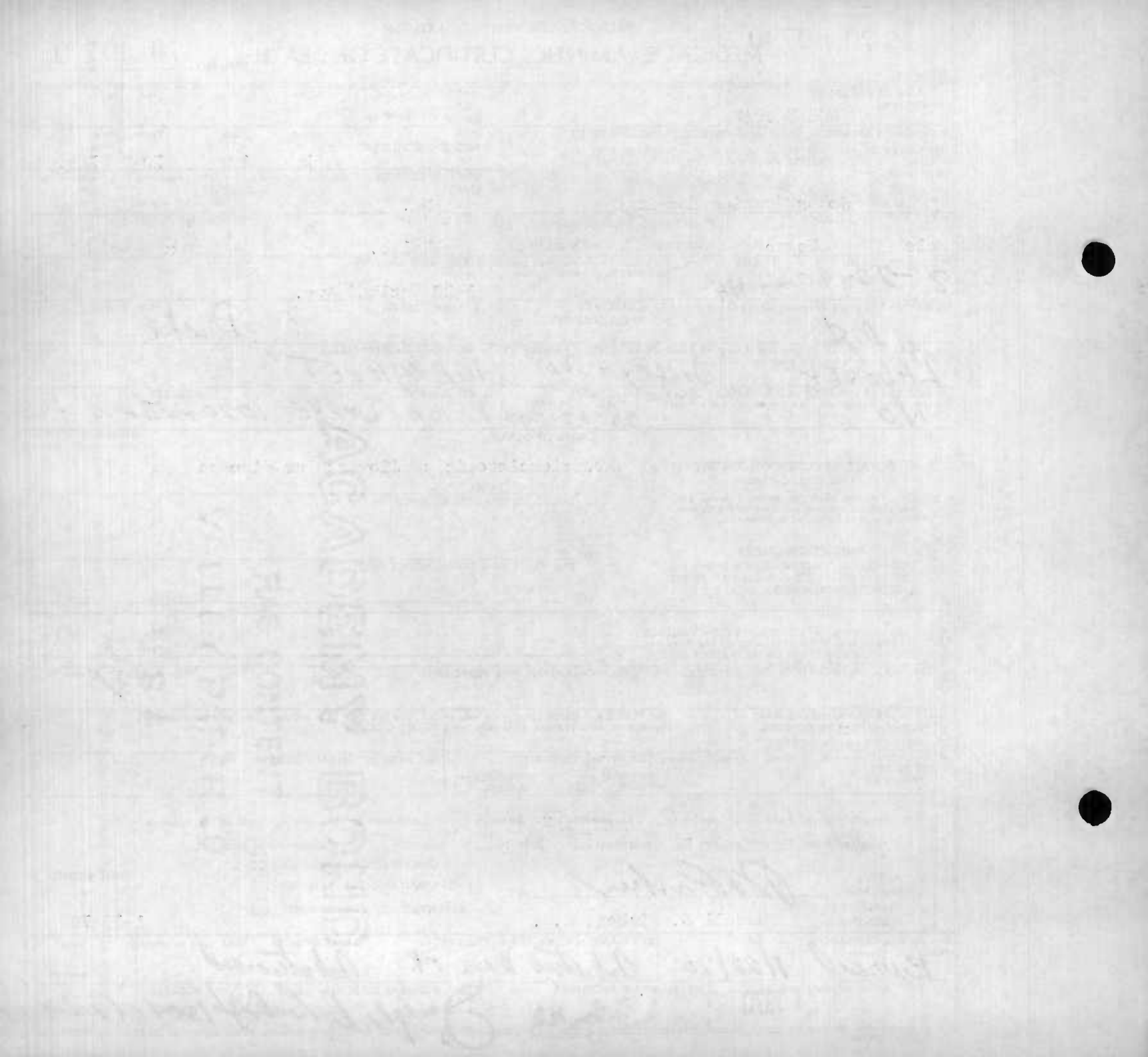


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MOREY DRAKE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 19 70 7 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8-20-90</b>		10. AGE (In years lost birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Colley &amp; Co</b>	
15. MOTHER'S MAIDEN NAME <b>MARGARET</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>016-87-1644</b>		18. INFORMANT <b>EMMA DRAKE</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-12-71</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u><i>Russell S. Fisher</i></u> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-19-70</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. PR.</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Mem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Joseph E. Fisher, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Joseph E. Fisher, Jr.</b>		ADDRESS <b>1304 N. Charles St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00701</u>	
BIRTH NO. <u>70 00701</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>George L. Hood</u>			2. DATE AND HOUR OF DEATH <u>January 19, 1970</u> <u>4:00 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hosp.</u> <u>44 Baltimore, Md. 21218</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3633 Malden Ave. 1338</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/86</u>	9. AGE (in years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Roland Park Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles Hood</u>			14. MOTHER'S MAIDEN NAME <u>Sara E. Holt</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-8888</u>		17. INFORMANT ADDRESS <u>Nat Grim - 3633 Malden Ave.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of the Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1/6/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1</u>		20A. AUTOPSY (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (the hospital) attended the deceased from <u>12/31</u> 19 <u>69</u> to <u>1/19</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>V. Chitraplee</u>			23B. DATE SIGNED <u>Jan. 19, 70</u>		
23C. PHYSICIAN'S NAME (Type) <u>V. Chitraplee</u>			23D. ADDRESS <u>North Charles General Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/23/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>	
24D. LOCATION <u>Carroll Co.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Sader</u>		25C. FUNERAL DIRECTOR <u>Ann Donovan</u>	
25D. ADDRESS <u>3818 Roland Ave.</u>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 00702		70 00702		70 00702	
1. NAME OF DECEASED (Type or Print) <b>BURRIER JAMES RICHARD</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 11 1970 1:00PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUE BALTIMORE MARYLAND 21229</b>			A. STATE <b>MARYLAND</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN <b>BALTIMORE</b>		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <b>15 S PROSPECT AVENUE 21228</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06/25/40</b>	9. AGE (In years last birthday) <b>29</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC - PARTS AUTO REPAIR</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
13. FATHER'S NAME <b>PAUL BURRIER</b>			14. MOTHER'S MAIDEN NAME <b>HEDWIG UNKNOWN SCHWIEZER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1959</b>			16. SOCIAL SECURITY NO. <b>220-36-8022</b>		
17. INFORMANT <b>ST AGNES HOSPITAL BALTIMORE MARYLAND</b>			ADDRESS		
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic Coma.</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Decompensated Cirrhosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Laennec's Cirrhosis - Chronic Alcoholism</b> (C) <b>13 years</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days -</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pneumonia (Pseudomonas)</b>					
19A. DATE OF OPERATION <b>1-11-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>01/05/70</b> 19 to <b>01/11/70</b> 19 that (X) (we) last saw the deceased alive on <b>01/11/70</b> 19 and that in (mX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dix) view the body after death.					
23A. SIGNATURE <b>Alejandro Mejia</b>			23B. DATE SIGNED <b>1-11-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA M.D.</b>			23D. ADDRESS <b>St Agnes Hospital Caton-Wilkens Aves</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-14-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>E. J. B. M.D.</b>		25C. FUNERAL DIRECTOR <b>John J. ...</b>	
25D. ADDRESS					

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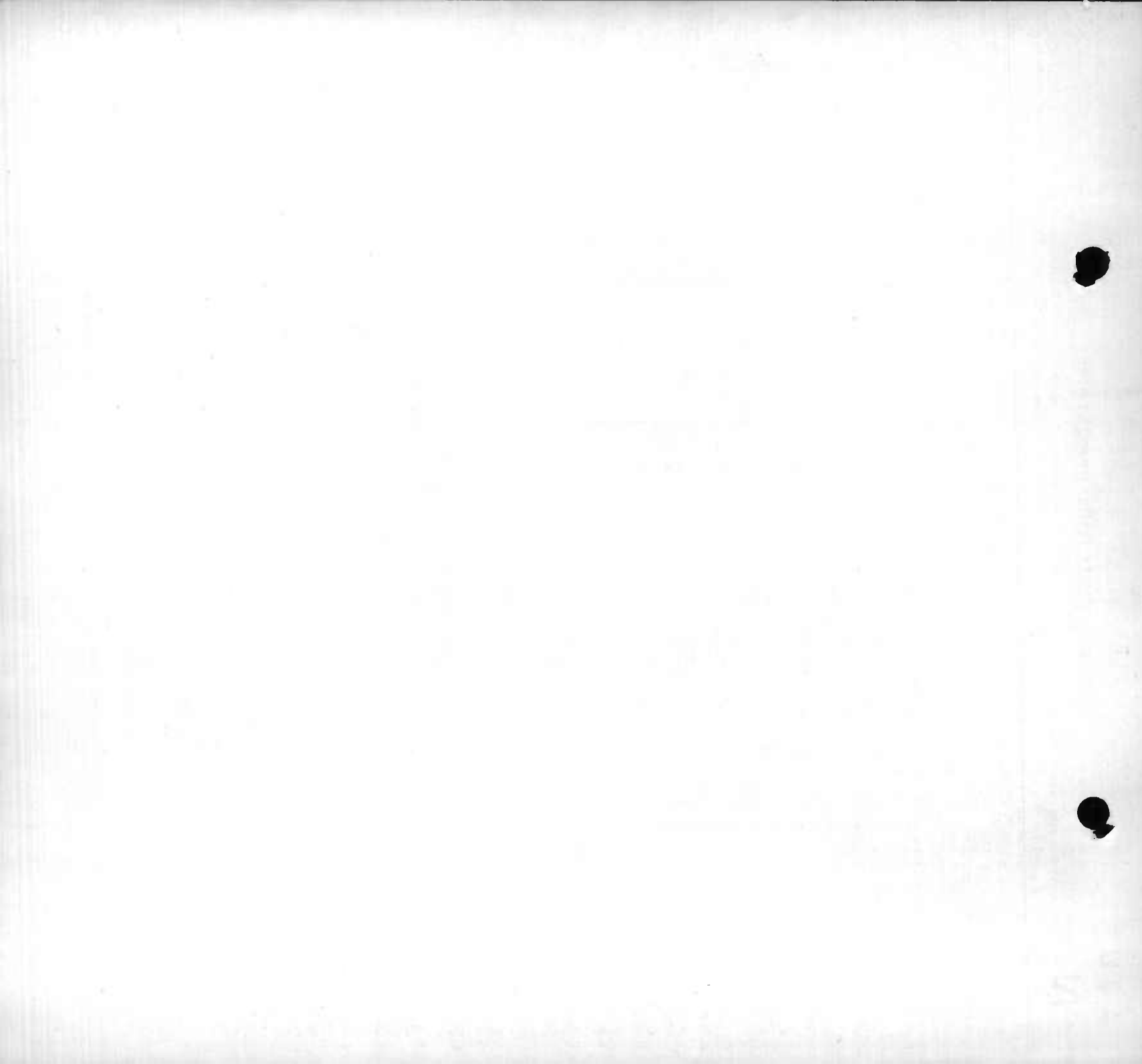
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00703 ✓	
BIRTH NO. 64-1419270 00703		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>NANCY MYERS</b>			2. DATE AND HOUR OF DEATH <b>Jan. 20, 1970 10:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2717</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2702 Calburn Ave. #15</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1964</b>	9. AGE (In years last birthday) <b>5</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>DOUGLAS Myers</b>			14. MOTHER'S MAIDEN NAME <b>VIOLA Winkey</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>-0-</b>	17. INFORMANT ADDRESS <b>Mr. Douglas Myers 2702 Calburn Ave</b>		
18. <b>204.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Heavenly</b> (B) <b>Lymphoblastic Leukemia, acute</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. <b>0</b> DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 20 1970</b> to <b>Jan. 20 1970</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 20 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23A. SIGNATURE <b>Blinda P. Jagade, M.D.</b>			23B. DATE SIGNED <b>1-20-70</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>1/23/70</b>		
24C. NAME of CEMETERY or CREMATORY <b>Balta Nat'l Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		
25C. FUNERAL DIRECTOR <b>Morton G. Dyett F.H.</b>			25D. ADDRESS <b>1701 KAYERS ST</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00704				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 00704	
1. NAME OF DECEASED (Type or Print) <u>Susie Cordery</u>				2. DATE AND HOUR OF DEATH <u>1/18/70</u> <u>9:17 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1303</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Maryland Gen'l Hosp.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt</u>			
				D. STREET ADDRESS (If rural, give location) <u>2415 McCulloh St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>11/17/98</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Nathaniel Corfer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Slowe</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Lawsence Cordery same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>250.01</u> <u>Diabetes mellitus</u>				CAUSE OF DEATH (A) DUE TO <u>Reboarsis</u> (B) DUE TO <u>24 hrs</u> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> <u>1970</u> to <u>1/18</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael B. Jones</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/18/70</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Moetony Dyett F.H.</u>		ADDRESS <u>1701 Laurens St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00705
BIRTH NO. 70 00705		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>MAXINE R. BURKS</b>		2. DATE AND HOUR OF DEATH <b>1-19-70 2<sup>15</sup> PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3714 GEISTON DR.</b>		
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-30</b>	9. AGE (In years lost birthday) <b>39</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b>		11. BIRTHPLACE (State or foreign country) <b>ALABAMA, CLANTON</b>
13. FATHER'S NAME <b>Rev. E.W. Burks</b>		14. MOTHER'S MAIDEN NAME <b>Lessie U. Lane</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. James Burks 3714 Geiston Dr.</b>
18. <b>582X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CHRONIC GLOMERULAR NEPHROSIS - 3 MO.</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>- 3 MO.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1-6-1970</b> to <b>1-19-1970</b> , that (I) (we) last saw the deceased alive on <b>1-19-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Violeta R. Gamarra</b>			23B. DATE SIGNED <b>1-19-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>VIOLETA R. GAMARRA, R. M.D.</b>			23D. ADDRESS <b>730 Ashburton St. Bal. Md 21216</b>	
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE <b>1/25/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balti. Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Robert E. Taylor, M.D. 1701 Laurens</b>

W/412-12-12

Jameson Hospital of Maryland 2114 Geisen Dr.  
F. M. 8-2-54

Albany

W/412



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00706				Baltimore City Health Department				REG. NO. 70 00706			
1. NAME OF DECEASED (Type or Print) <b>FERGUSON, Fernando</b>						2. DATE AND HOUR OF DEATH <b>19 JANUARY 1970 12:10P</b> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>						A. STATE B. COUNTY <b>MARYLAND BALTIMORE CITY 1601</b>					
						C. CITY OR TOWN <b>BALTIMORE</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
						E. STREET AND NUMBER <b>827 ARLINGTON AVENUE</b>					
5. SEX <b>male</b>		6. RACE <b>NEGROID</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-97</b>		9. AGE (In years last birthday) <b>72</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bulter</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ANDERSON, SOUTH CAROLINA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>THOMAS FERGUSON</b>						14. MOTHER'S MAIDEN NAME <b>SALLIE JOHNSON</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>MES 8-22-18 TO 7-29-19</b>						16. SOCIAL SECURITY NO. <b>217-20-87-72</b>		17. INFORMANT <b>VA HOSPITAL RECORDS</b>			
						ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>					
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST, ARTERIOSCLEROTIC</b>						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO VASCULAR DISEASE W/CARDIOMEGLAY</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) <b>PULMONARY EMBOLI (SUSPECT)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>12 HOURS</b>					
						(C) <b>CONGESTIVE HEART FAILURE</b> <b>YEARS</b>					
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>16 JANUARY 19 70</b> to <b>19 JANUARY 19 70</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>19 JANUARY 19 70</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Marcia C. Schmidt M.D.</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>1-20-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>MARCIA C. SCHMIDT, MD</b>						23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-23-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens Street</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00707</u>
BIRTH NO. <u>70 00707</u>		1. NAME OF DECEASED (Type or Print) <u>MARY BELLE DEWITTE</u>		
2. DATE AND HOUR OF DEATH <u>01-20-70</u> <u>12:55 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>THE UNION MEMORIAL HOSPITAL</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE UNION MEMORIAL HOSPITAL</u>		
6. CITY OR TOWN <u>BALTIMORE</u>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. STREET AND NUMBER <u>402 CALVIN AVENUE</u>		9. SEX <u>FEMALE</u> 10. RACE <u>WHITE</u>		
11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH <u>12-11-1883</u>		
13. AGE (In years last birthday) <u>86</u>		14. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(NONE) RETIRED HOMEMAKER</u>		16. KIND OF BUSINESS OR INDUSTRY		
17. BIRTHPLACE (State or foreign country) <u>U.S.A. (N.C.)</u>		18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
19. FATHER'S NAME <u>JAMES R. WOMBLE</u>		20. MOTHER'S MAIDEN NAME <u>MOLLIE WILLETT</u>		
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		22. SOCIAL SECURITY NO. <u>218-52-1307</u>		
23. INFORMANT <u>(HERSELF)</u>		24. ADDRESS <u>MRS. LUCILLE D. RUTTERS 402 CALVIN AVE. (2-12-18)</u>		
18. CAUSE OF DEATH <u>412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>(B) CONGESTIVE HEART FAILURE 10 YEARS</u> <u>(C) HYPERTENSIVE CARDIOVASCULAR DISEASE</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>01-06-70</u> 19 <u>70</u> to <u>01-20-70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>01-20</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Yasumasa Yamasaki M.D.</u>				23B. DATE SIGNED <u>01-20-70</u>
23C. PHYSICIAN'S NAME (Type) <u>YASUMASA YAMASAKI</u>		23D. ADDRESS <u>M.D. 33RD AND CALVERT STREETS, BALTO. MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>1/21/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenwood</u>
24D. LOCATION <u>Apopka, Florida</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>		

THE  
OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY, N. Y.  
JANUARY 1, 1902

TO THE  
COMMISSIONER OF THE  
LAND OFFICE

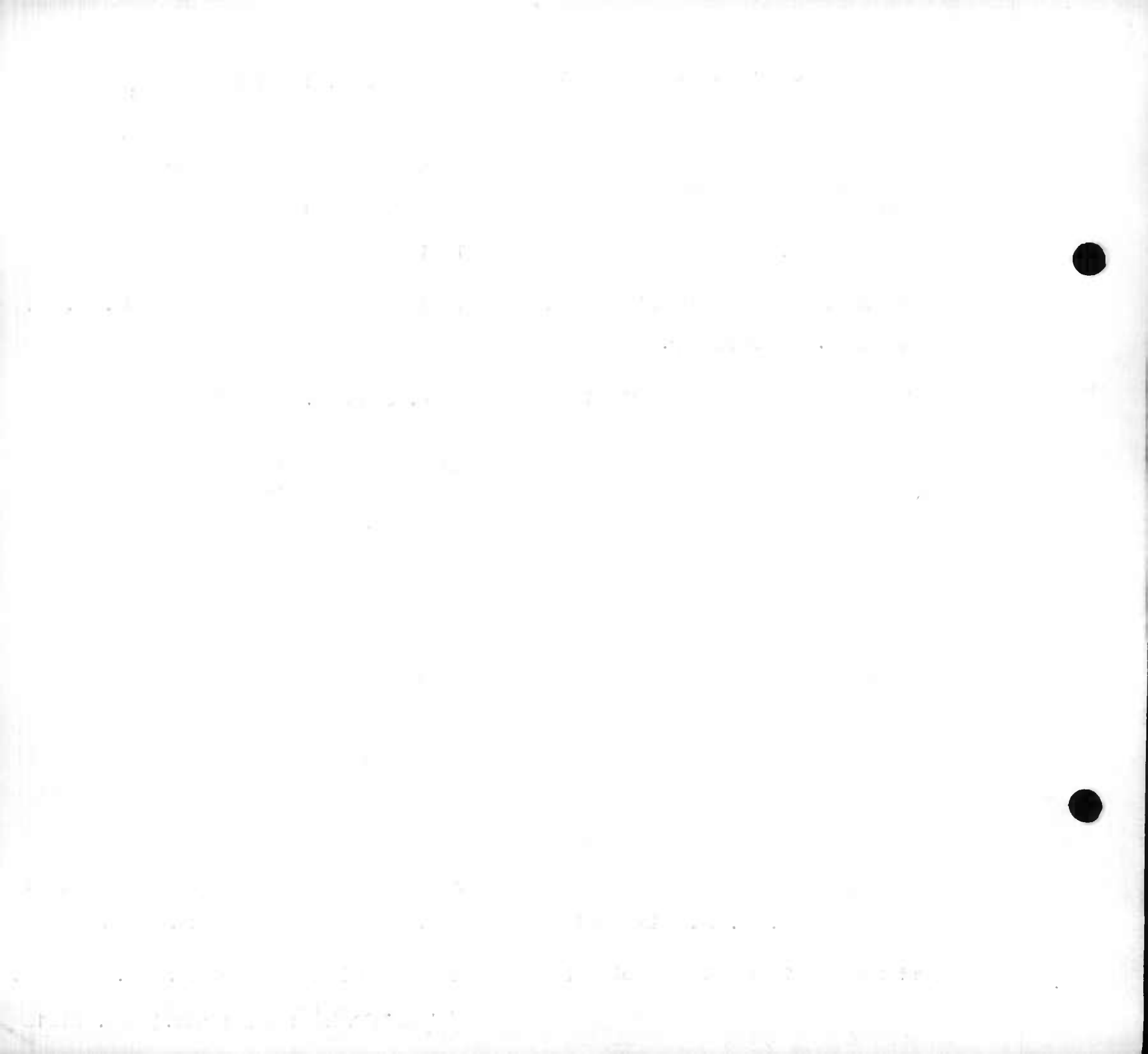
NY

RE: [illegible]  
[illegible]  
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00708</u>	
BIRTH NO. <u>70 00708</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>John Winthrop Wolcott</u>		2. DATE AND HOUR OF DEATH <u>Jan. 18, 1970</u> <u>2:35</u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>3953 Cloverhill Road</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3953 Cloverhill Road</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1895</u>	9. AGE (in years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Proprietor Architect Griffin, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John W. Wolcott, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ella Barnes</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-3850</u>		17. INFORMANT <u>Mrs. John W. Wolcott</u> ADDRESS <u>Same</u>	
18. <u>433.91</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
(A) IMMEDIATE CAUSE <u>Cerebral thrombosis with</u> DUE TO, OR AS A CONSEQUENCE OF: <u>left hemiplegia</u>					
(B) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the deceased) attended the deceased from <u>1950</u> <u>19</u> to <u>January 18</u> <u>1970</u> that (I) <u>yes</u> last saw the deceased alive on <u>January 18</u> <u>1970</u> and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) <u>yes</u> (or) (did not) view the body after death.					
23A. SIGNATURE <u>Crawford N. Kirkpatrick</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. C. N. Kirkpatrick</u>				23B. DATE SIGNED <u>January 20, 1970</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-21-1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Jenkins &amp; Sons Co.</u> ADDRESS <u>0 74905 8 York Road Balto.; Md. 21212</u>			



B-522

70 00709

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00709

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) H. JOHN BENJES2. DATE OF DEATH  
Known ☐ Estimated ☐ 1 19 70 3:05 p.m.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
Mercy Hospital3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
January 19, 1970 3:05 p.m.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY Baltimore

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

White

WIDOWED ☐DIVORCED ☐Balto. 21212YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years lost birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

11/31/1905643 McKim Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

MarylandRichard Benjes

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

ProprietorAnchor HotelUnknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

NoMrs. Geraldine Benjes (Same)E 884 X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Subdural hemorrhage  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

1 2 70?? ? m.WHILE AT WORK ☐NOT WHILE AT WORK ☒Subject apparently fell out of bedI certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)Isidore Mihalakis, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/70

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial1/22/70Loudon ParkBaltimore Md.

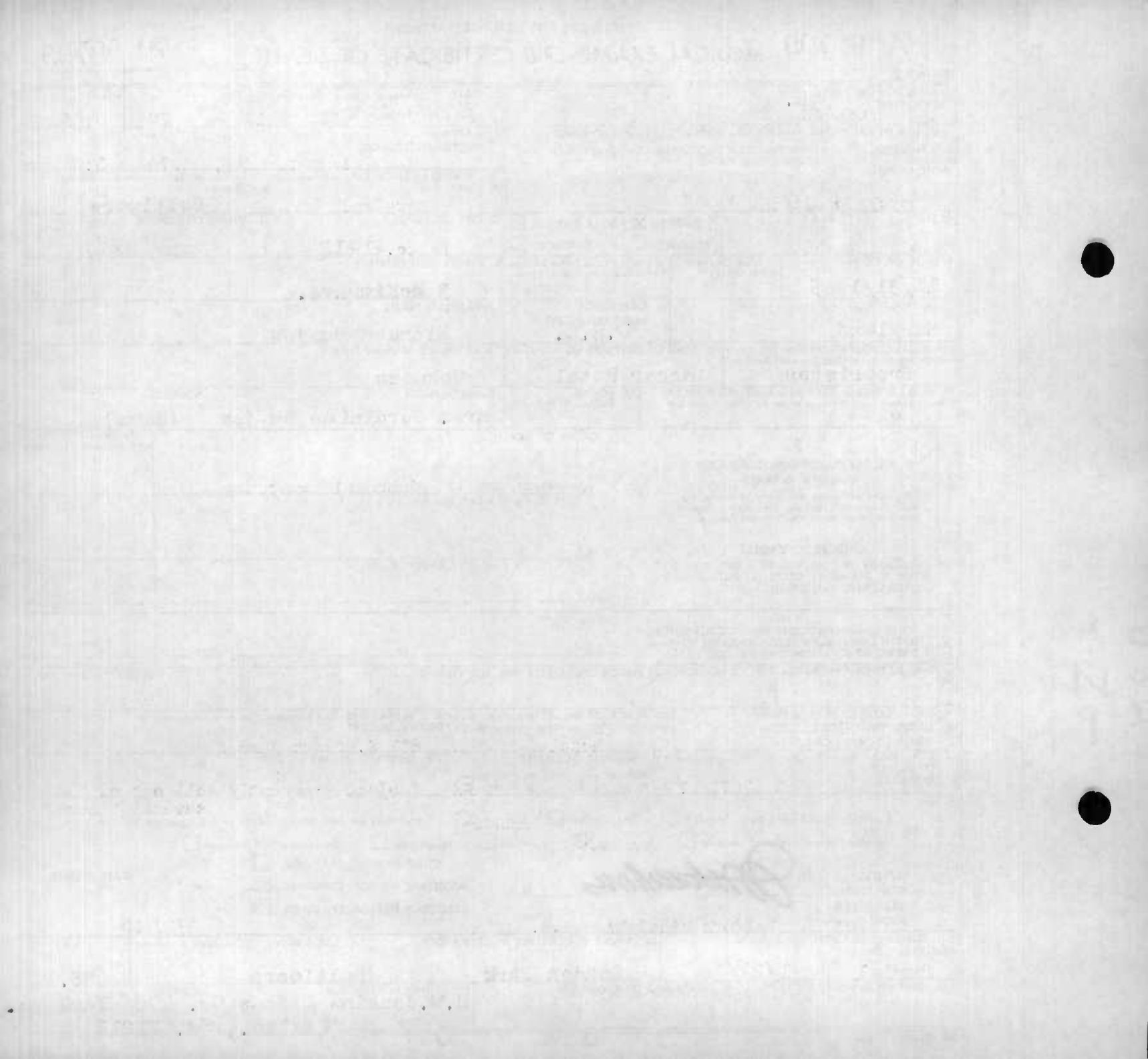
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 21 1970Robert E. Jenkins, M.D.H.W. Jenkins & Sons Co. 4905 York Rd.Balto., Md. 21212

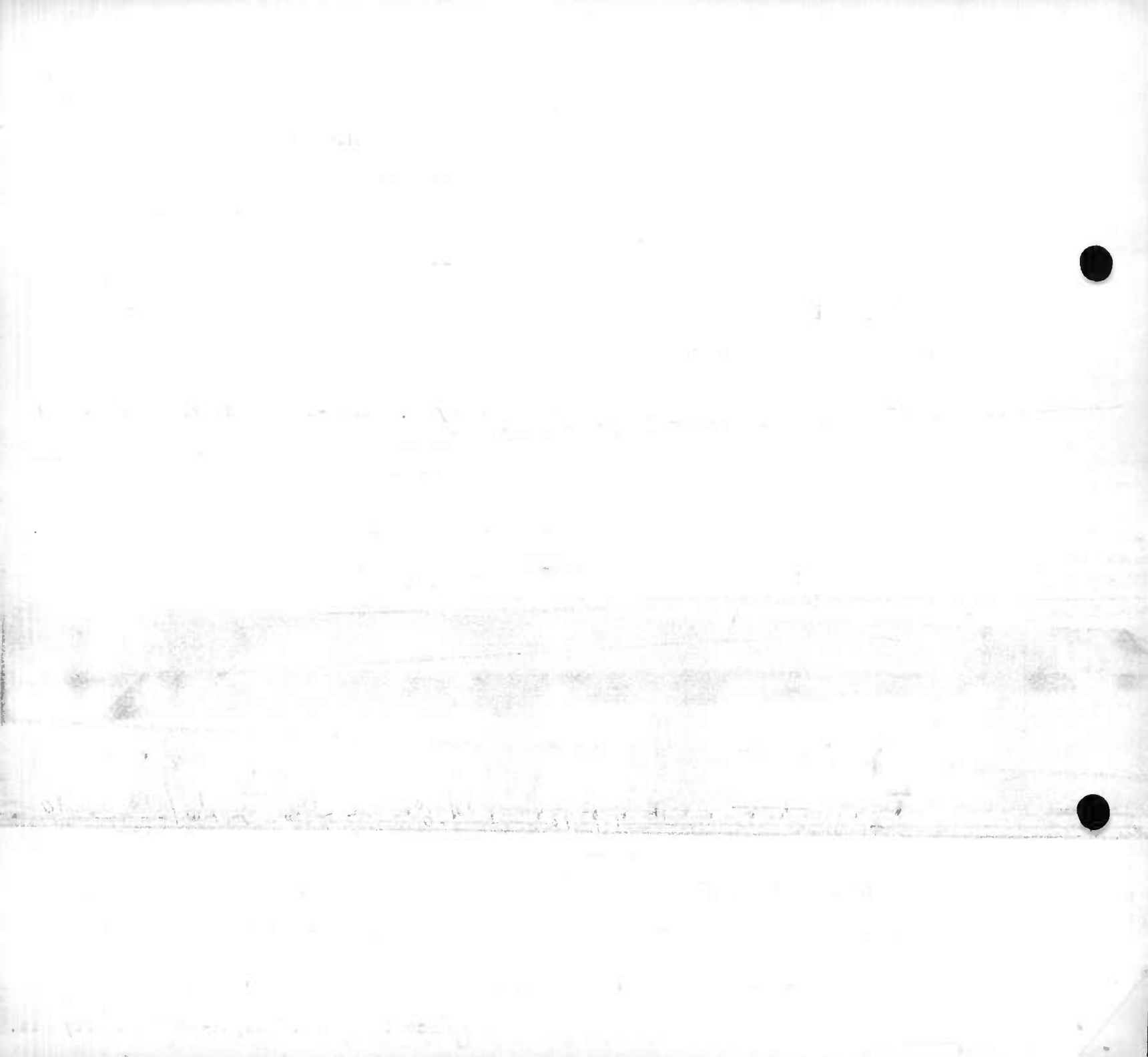




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00710	
BIRTH NO. 70 00710		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MRS. LETA C. KELLER.</b>		2. DATE AND HOUR OF DEATH <b>1/18/70 12 30/p M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL 42025 W FAYETTE ST. BALTO. MD, 21223</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/20/03</b> 9. AGE (In years last birthday) <b>66</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEO. SAMUEL ARNOLD</b>		14. MOTHER'S MAIDEN NAME <b>EMMERICH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Harry M. Keller-5114 Belleville Avenue #7</b>		ADDRESS	
18. <b>41223 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>ERRHMITRAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>BRONCHIAL ASTHMA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>DIVERTICULITIS.</b>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> 19 <b>70</b> to <b>1/18</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Orathai Thirawat</b> M.D. DEGREE		23B. DATE SIGNED <b>1/18/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT</b> M.D. DEGREE		23D. ADDRESS <b>BON SECOURS HOSPITAL BALTO, MD 23</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>	
24C. NAME of CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tubey M.D.</b>	
25C. FUNERAL DIRECTOR <b>Armagost Funeral Chapel-4600 Liberty Hts.</b>		ADDRESS	



70 00711

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

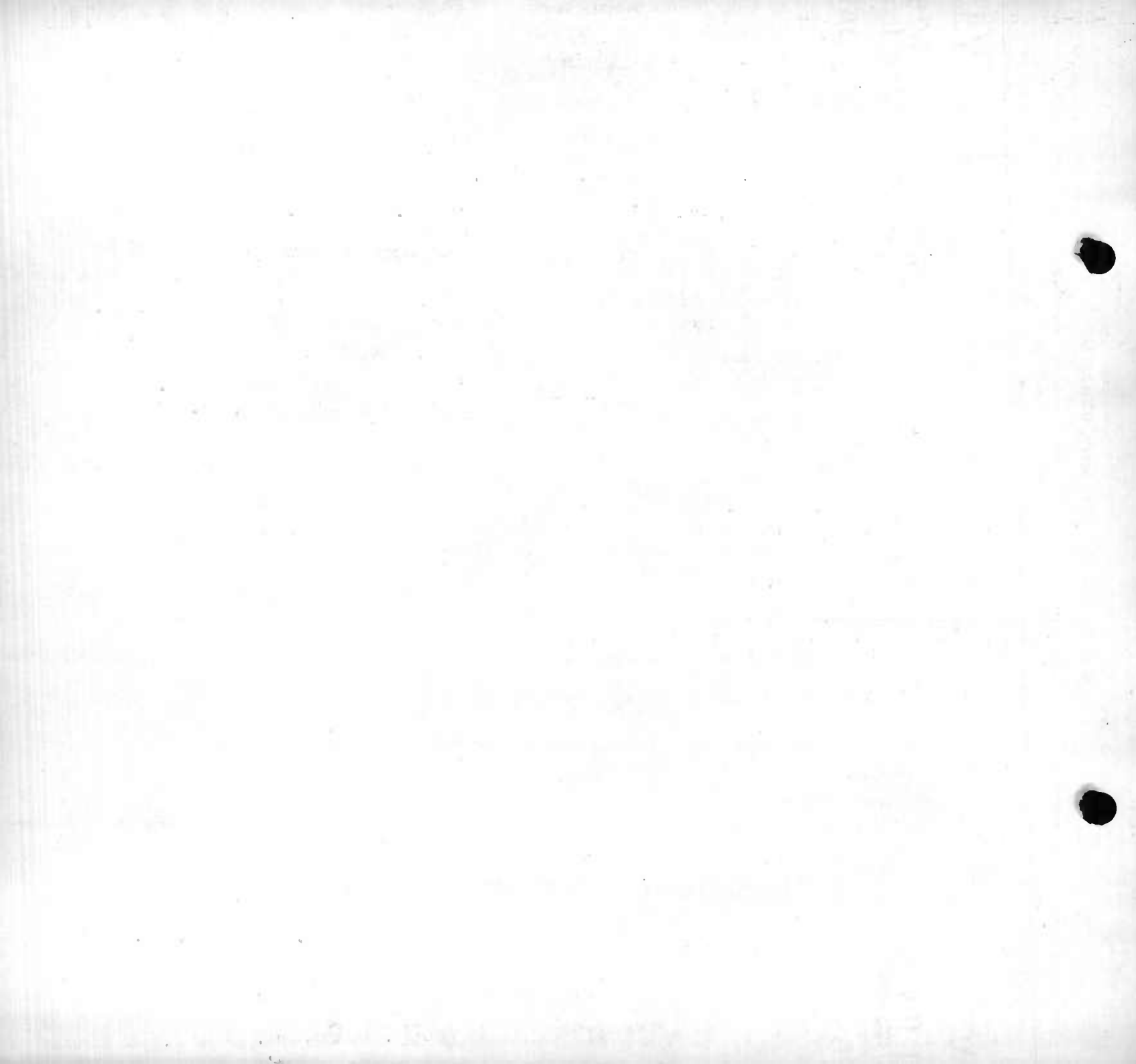
REG. NO.

70 00711

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

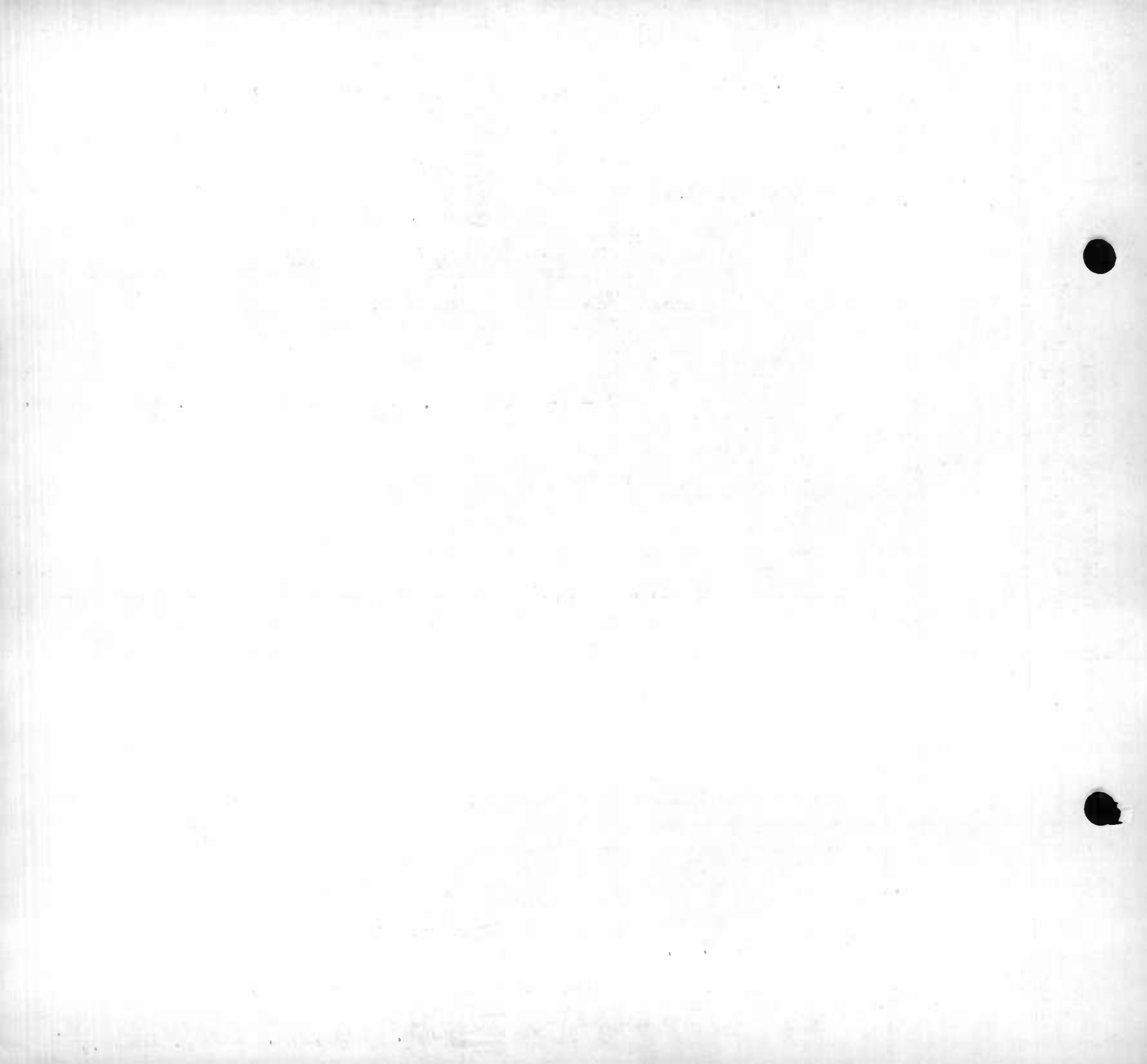
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret Soehnlein</i>		2. DATE AND HOUR OF DEATH <i>11/17/70 1155 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2608</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Ave.</i> <i>Baltimore, Md. 21224</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>3412 E. Pratt St. 21224 007</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-10-1917</i>	9. AGE (In years last birthday) <i>52</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Short order cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Little Tavern</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Bellingham</i>			
14. MOTHER'S MAIDEN NAME <i>unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>217-16-1999</i>		17. INFORMANT <i>4940 Eastern Ave.</i> <i>BCH Records: Baltimore Md. 21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>571.0 I</i> <b>CAUSE OF DEATH</b> <i>cirrhosis of liver</i> <b>ANTECEDENT CAUSES</b> <i>chronic alcoholism</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>1/2</i> 19 <i>70</i> to <i>1/17</i> 19 <i>70</i> , that (1) (we) lost saw the deceased alive on <i>1/17</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dale P. Henken M.D.</i>				23B. DATE SIGNED <i>11/17/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>DALE P. HENKEN M.D.</i>		23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave. Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1/21/70</i>	24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1970</i>	25B. NAME OF REGISTRAR <i>Robert E. J. J. J.</i>	25C. FUNERAL DIRECTOR <i>John A. Morgan, Inc. 3000 E. Baltimore</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-240		70 00712		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00712	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Frank P. Loechel</i>				January 18, 1970 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 Johns Hopkins Hospital</i>				A. STATE <i>Maryland</i>		B. COUNTY <i>701</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>520 N. Linwood Avenue</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/28/'87</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meatcutter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Frank's Market</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>? Loechel</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-01-4770A</i>		17. INFORMANT ADDRESS <i>Mrs. Sarah Loechel 520 N. Linwood Ave.</i>			
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Colitis</i>				<i>1 wk</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>16 Aug 1948</i> to <i>10 Jan 1970</i> , that (I) (we) last saw the deceased alive on <i>10 Jan 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Howard Goodman</i>				23B. DATE SIGNED <i>20 Jan 70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Howard Goodman, M.D.</i>				23D. ADDRESS <i>8604 Harford Road</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/'70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>		ADDRESS <i>3000 E. Balto. St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00713		CERTIFICATE OF DEATH		X REG. NO. 70 00713	
1. NAME OF DECEASED (Type or Print) <i>John Barry - SR.</i>				2. DATE AND HOUR OF DEATH <i>January 17, 1970 1:50 AM</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>				C. CITY OR TOWN <i>EAST POINT</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <i>7250 GOUGH ST.</i>					
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/5/17</i>	9. AGE (in years last birthday) <i>53</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>CITY</i>		11. BIRTHPLACE (State or foreign country) <i>PA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>JOHN BARRY</i>				14. MOTHER'S MAIDEN NAME <i>FLORENCE BEGGS</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW II</i>		16. SOCIAL SECURITY NO. <i>218-01-0574</i>		17. INFORMANT <i>JOHN BARRY JR.</i>		ADDRESS <i>ABOVE</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute myocardial infarction 22 days</i> (B) <i>Severe Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 10</i> 19 <i>70</i> to <i>Jan 17</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>Jan 17</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Victor Hernandez</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>Victor Hernandez</i>				23D. ADDRESS <i>University of Maryland Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/21/70</i>		24C. NAME of CEMETERY or CREMATORY <i>BALTO. NATL. CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1970</i>		25B. NAME OF REGISTRAR <i>J. E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>J. G. CONNELLY SONS</i>		ADDRESS <i>300 MACE</i>			





# FUNERAL DIRECTOR: IMPORTANT

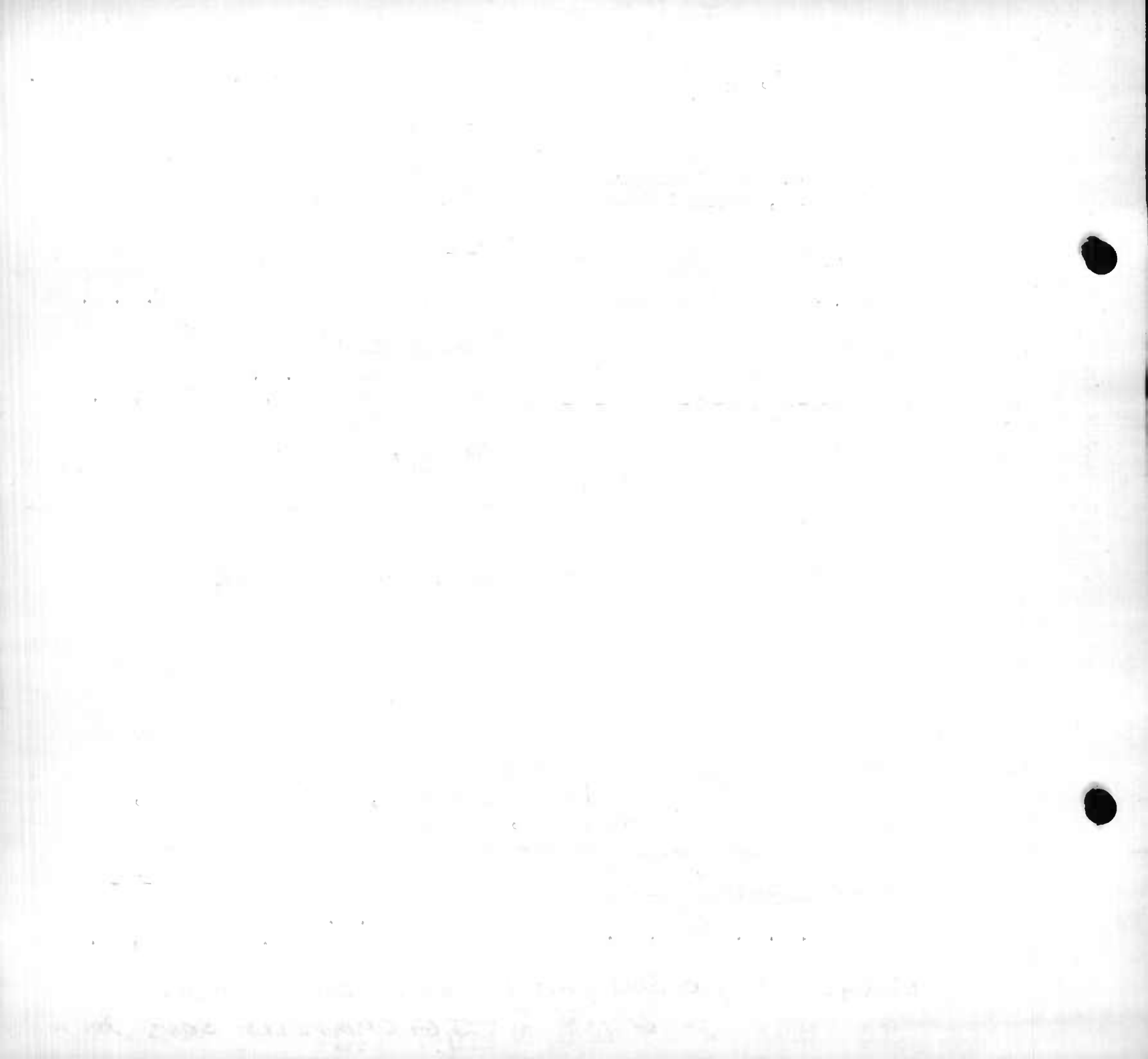
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 00714

BIRTH NO. 70 00714		1. NAME OF DECEASED (Type or Print) BARONE, JOSEPH DOMINIC		2. DATE AND HOUR OF DEATH January 18, 1970 6:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			A. STATE B. COUNTY Maryland Baltimore		
23			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 7641 Highpoint Road		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-16	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery man		10B. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Angelo Barone			14. MOTHER'S MAIDEN NAME Rachael Pietropaulo		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3-5-41 to 9-23-41		16. SOCIAL SECURITY NO. 114-10-5446	17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md. 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carcinoma of lungs with metastasis to liver, spleen, kidney and skin			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Abscess of lungs secondary to 1			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Empyema of left lower lobe of lung			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify (this hospital) attended the deceased from January 6, 1970 to January 18, 1970, that (we) last saw the deceased alive on January 18, 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. G. S. Jewell, MD.				23B. DATE SIGNED 1-19-70	
23C. PHYSICIAN'S NAME (Type) M. G. S. Jewell, MD.				23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/22/70		24C. NAME OF CEMETERY or CREMATORY BALTO. NATL. CEM.	
				24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1970		25B. NAME OF REGISTRAR Robert E. Farber, Jr.		25C. FUNERAL DIRECTOR J G GONNELLY SONS 300 MAC	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00715	
70 00715		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LILY MAY HARDING</u>		Jan. 14, 1970 10:10 Pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 Saint Agnes Hospital</u> <u>Caton &amp; Wilkens Ave.</u> <u>Baltimore, Maryland 21229</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Haward</u>	
5. SEX <u>Female</u>		C. CITY OR TOWN <u>Savage</u>	
6. RACE <u>White</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>101 Woodward Street</u>	
8. DATE OF BIRTH <u>May 24, 1888</u>		9. AGE (in years last birthday) <u>81</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Haward Co, Md</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Larkin Braun</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Braun</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ida Braun - above</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412.41</u> <u>Arteriosclerotic Cordis Vase.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs -</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart Arteriosclerosis</u> 21 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> 19 <u>70</u> to <u>1/14</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Jan 14</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John Warren M.D.</u>		23B. DATE SIGNED <u>1/14/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Warren M.D.</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Savage Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Donald H. Farber</u>		ADDRESS <u>Farber M.D.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00716

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

70 00716

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILDRED P.

MASSEY

2. DATE AND HOUR OF DEATH

JANUARY 17, 1970

11:15 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4030 Elmora Ave. 21213

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

JUNE 7, 1900

9. AGE (in years last birthday)

69

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN PACKARD

14. MOTHER'S MAIDEN NAME

MARY ELIZABETH Hardester

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

217-01-4643A

17. INFORMANT

CLARENCE MASSEY, SR. 4030 ELMORA AVE BALTO., MD.

ADDRESS

18.

436.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

2 days

(B) CEREbro-VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF:

(C) ARTERIO-SCLEROTIC VASCULAR DISEASE

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 16 1970 to JAN 17 1970 that (I) (we) last saw the deceased alive on JAN 17 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

YU, SUI LIT

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/17/70

23D. ADDRESS

UNION MEMORIAL HOSP., BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/20/70

24C. NAME OF CEMETERY OR CREMATORY

Sunnyridge Cemetery

24D. LOCATION (City, town, or county) (State)

Crisfield, Somerset, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1970

25B. NAME OF REGISTRAR

Robt E. J. J. J.

25C. FUNERAL DIRECTOR

Bradshaw & Sons, Crisfield, Md. 21817

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00717	
70 00717		70 00717	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>CHARLES E. JOYNES</b>		1-19-70 1:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>RETHURCH (HOME + HOSPITAL)</b> <b>1500 N. BROADWAY, BALTO. MD.</b>		A. STATE <b>MD</b> B. COUNTY <b>BALTO. CO.</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>42 WILTSHIRE Rd (21)</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-01-03</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		9. AGE (In years last birthday) <b>66</b>	11. BIRTHPLACE (State or foreign country) <b>VA</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES JOYNES</b>		14. MOTHER'S MAIDEN NAME <b>WIMPLE ROSS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>224288674</b>	
		17. INFORMANT <b>PATIENT</b>	
		ADDRESS	
18. <b>674.9 + 143.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RENAL FAILURE to ARTERIOSCLEROSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CONGESTIVE HEART FAILURE</b> - 3 days	
		(B) <b>BILATERAL PNEUMONIA</b> - 6 days	
		(C) <b>Surgical operation &amp; Anesthesia</b> 1-12-70	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>C. Cecum, Cholelithiasis (operated)</b> 1-12-70	
19A. DATE OF OPERATION <b>1-12-70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholelithiasis</b>	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-19</b> 19 <b>67</b> to <b>1-19</b> 19 <b>70</b> and that (I) (we) last saw the deceased alive on <b>1-19</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ricardo M. Tusson M.D.</b>			23B. DATE SIGNED <b>1-19-70</b>
23C. PHYSICIAN'S NAME (Type) <b>Ricardo M. Tusson M.D.</b>			23D. ADDRESS <b>100 N BROADWAY ST.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-22-70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT. HOLLY CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>ONANCOCK, VIRGINIA</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>	25B. NAME OF REGISTRAR <b>Bob E. Taylor R.D.</b>	25C. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b> ADDRESS <b>4107 WILKENS AVE. 21229</b>	

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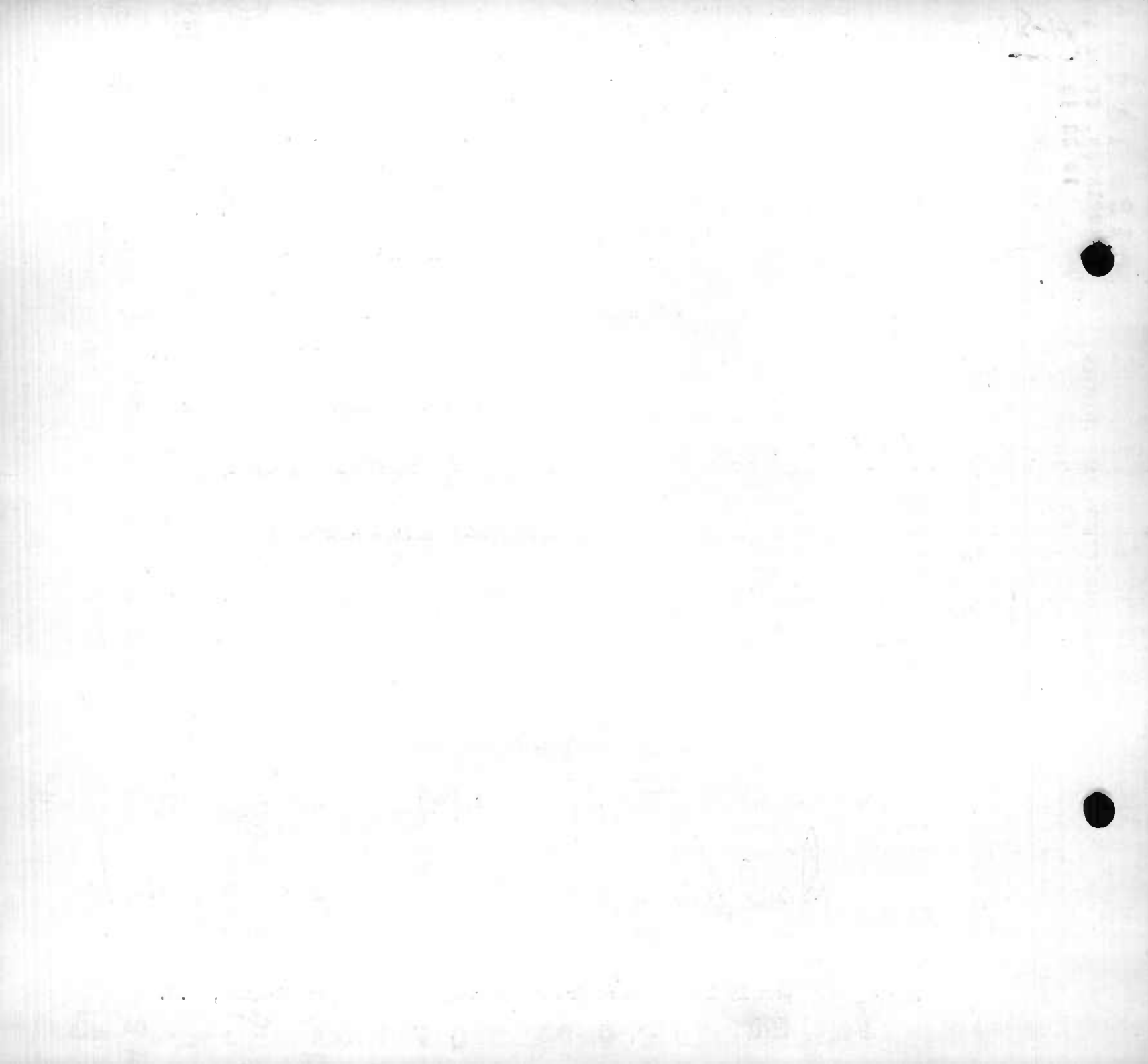
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

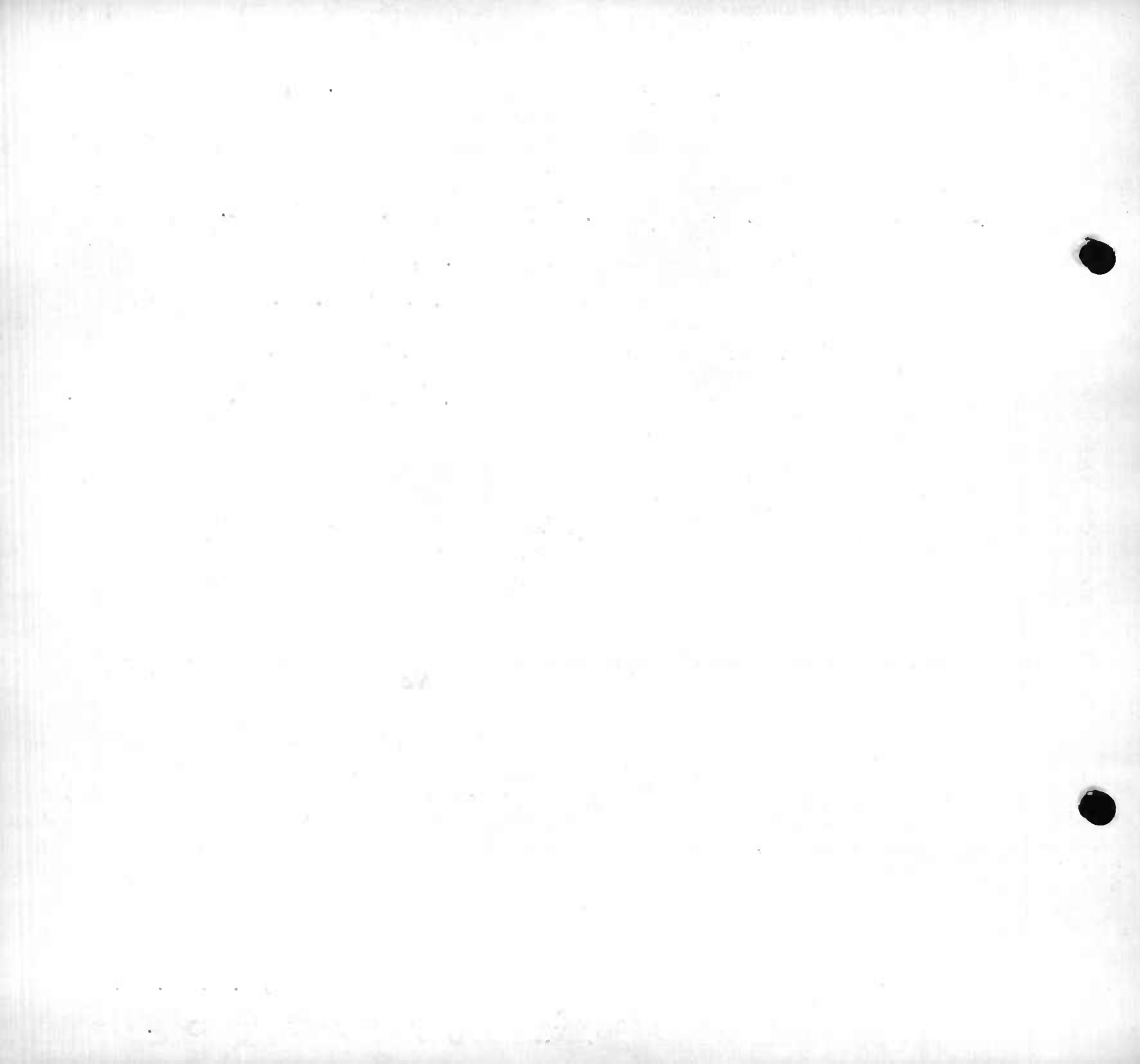
BALTIMORE CITY HEALTH DEPARTMENT				70 00718		REG. NO. 70 00718	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				ZAIDA M. ANDERSON		1. 17.70 12:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				WASHINGTON D.C.		V-48	
33				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4400 HAWTHORNE ST N.W.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-22-15	
						9. AGE (In years lost birthday) 54	
						11. BIRTHPLACE (State or foreign country)	
						MISSOURI	
						12. CITIZEN OF WHAT COUNTRY?	
						USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				OWN HOME		MISSOURI	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM McGUIRE				JESSIE JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						GEORGE ANDERSON ITEM # 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				METASTATIC DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) PRIMARY CARCINOMA OF BREAST			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12/29 to 1/17/70 and that (I) (we) last saw the deceased alive on 1/17/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David Lerberg, MD				1/17/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAVID LERBERG				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jan 19 1970		Rock Creek Cemetery		Washington, D.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 22 1970		Joseph Gawler's Son, Inc.		JOSEPH GAWLER'S SON, INC.		6130 WISC. AVE., N. W. WASH., D. C. 20010	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00719</span>	
BIRTH NO. <span style="float: right;">70 00719</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Anna M. Thomas</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">Jan. 19, 1970 1:45 P M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 207 E. Montgomery St.			A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">2201</span>		
			C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="float: right;">207 E. Montgomery St.</span>		
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">Jan. 6, 1899</span>	9. AGE (In years last birthday) <span style="float: right;">71</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Seamstress</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Clothing</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">St. Mary's Co. Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U S A</span>			13. FATHER'S NAME <span style="float: right;">John Bradburn</span>		
14. MOTHER'S MAIDEN NAME <span style="float: right;">Magdeline Ridgel</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <span style="float: right;">Mrs. Mary French 207 E. Montgomery St.</span>		
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Uremia</span> <span style="float: right;">Central venous catheter accident</span> <span style="float: right;">Generalized arteriosclerosis</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Jan 19 1970</span> to <span style="float: right;">Jan 19, 1970</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">Jan. 6</span> 19 <span style="float: right;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">R. L. L. L.</span>				23B. DATE SIGNED <span style="float: right;">1/19/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">R. L. L. L.</span>				23D. ADDRESS <span style="float: right;">1225 S. Ches St. Baltimore</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">1 22 70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Holy Cross</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">Brooklyn, A. A. Co. Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">JAN 22 1970</span>			
25B. NAME OF REGISTRAR <span style="float: right;">J. J. J. J.</span>		25C. FUNERAL DIRECTOR <span style="float: right;">M. J. J. J.</span>		ADDRESS <span style="float: right;">130 E. Fort Ave</span>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00720

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY TREPOLSKY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 16, 1970</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 16, 1970</b>		Hour <b>7:40 A. M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>Baltimore</b>		CITY OR TOWN <b>Baltimore</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8 OCT 1899</b>		10. AGE (In years last birthday) <b>70</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooking</b>	
15. MOTHER'S MAIDEN NAME <b>Sophie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>412-41</b>	
18. INFORMANT <b>Mrs. Sonya T. Cohn</b>		ADDRESS <b>6723 B Townbrook Drive</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>1/16/70</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 16, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Friendship</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24F. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. ADDRESS <b>9610 Reisterstown Rd</b>			

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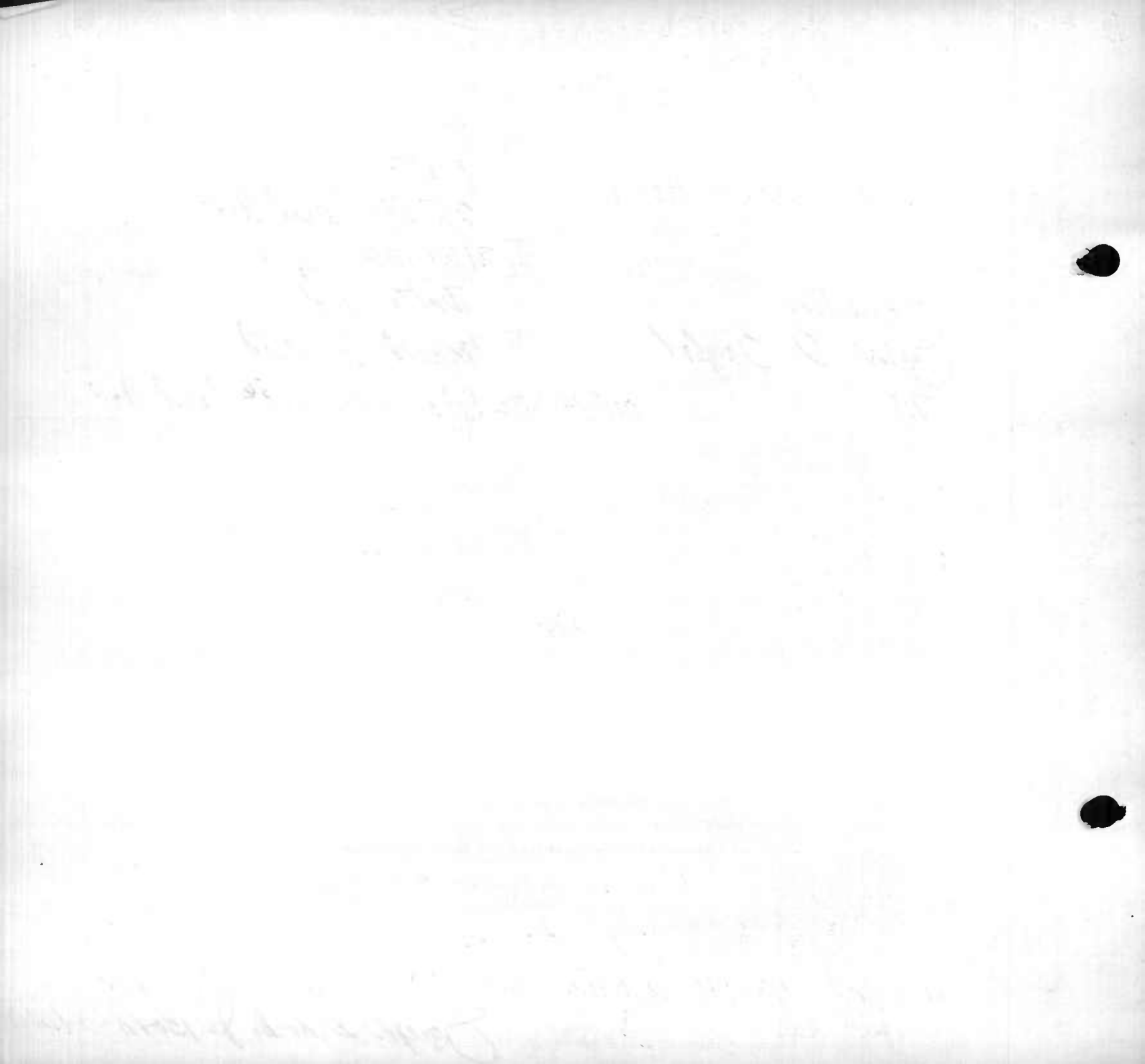
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 00721
BIRTH NO.		70 00721		TAYLOR	
1. NAME OF DECEASED (Type or Print)		Dean. Loretta.		2. DATE AND HOUR OF DEATH 1/19/70 630 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		907	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN Balt.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Union Mem. Hosp		E. STREET AND NUMBER 25-56 Cecil Ave			
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/22	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balt. Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John J. Taylor		14. MOTHER'S MAIDEN NAME Mabel Armistead	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-7932		17. INFORMANT Reta Taylor 25-56 Cecil Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 183.0 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: terminal stage of ovarian carcinoma. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph L. Kitchener		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Joseph L. Kitchener	
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE 1/28/70		24C. NAME OF CEMETERY or CREMATORY Antebellum Mem. Pk	
24D. LOCATION (City, town, or county) (State) A.A. County, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 22 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Joseph L. Kitchener		25D. ADDRESS 1507 N. Central Ave			





A-165

70 00722

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X REG. NO.

70 00722

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Annie Abrams		1/17/70 5:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Sinai Hospital of Baltimore				A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
				City	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				Belvedere Ave. At Greenspring	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. AGE (in years last birthday)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6/21/88	88	88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				W. Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Simon				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				Dr. Carlos R. Perez	
				ADDRESS	
				Sinai Hospital	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarct					
(B) ASCUD					
(C) Coronary Insufficiency					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/12/70 to 1/17/70 that (I) (we) last saw the deceased alive on 1/17/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Carlos R. Perez					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Carlos R. Perez				Sinai Hospital of Balto.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/19/1970		Beth Hamedoon Hazod	
				Balto	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 22 1970		J. E. J. J. J.		Sylvan J. J. J. J.	
				ADDRESS	
				9610 Reisterstown Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

(Called Sinai)

Last address type: Odessa was  
7506 Shale Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00723</u>
BIRTH NO. <u>70 00723</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>LANTZ, Margaret E.</u>		2. DATE AND HOUR OF DEATH <u>1-21-70</u> <u>2:25 A.M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNESE HOSPITAL</u>		A. STATE <u>MD.</u> B. COUNTY <u>21223</u> <u>2102</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>40</u>		E. STREET AND NUMBER <u>1111 SARGENT ST.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-01</u>	9. AGE (in years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Feeley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mc Dermott</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>AVES. BALTO MD.</u> ADDRESS <u>21229</u> <u>ST. AGNES HOSP RECORDS-CATON &amp; WILKENS</u>
18. <u>4-10-81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute MI.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary disease, severe atherosclerosis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary disease, severe atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (justify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW OLD INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 21</u> 19 <u>70</u> to <u>JANUARY 21</u> 19 <u>70</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 21</u> 19 <u>70</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.				
23A. SIGNATURE <u>Chang Hui Tsai, M.D.</u>		23B. DATE SIGNED <u>1-21-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Chang Hui Tsai, M.D.</u>		23D. ADDRESS <u>St Agnes Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1 24 70</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>	25B. NAME OF REGISTRAR <u>R. J. E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>Mc Cully</u>	ADDRESS <u>130 E. Fort Ave</u>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00724</u>	
BIRTH NO. <u>70 00724</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>GILLEY, GENEVA R.</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 17th 1970</u>   <u>10:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Mem. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1207</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>322 W. 30th STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-26-25</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOHN REED</u>		14. MOTHER'S MAIDEN NAME <u>CORA HICKMAN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>227-24-7032</u>		17. INFORMANT <u>HUGH GILLEY</u> ADDRESS <u>SAME AS ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic pyelonephritis.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brachymercuria</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>X.S.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 6th 1970</u> to <u>JANUARY 17th 1970</u> , that (I) (we) lost saw the deceased alive on <u>JANUARY 17th 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Cabrera</u> M.D.		23B. DATE SIGNED <u>1/17/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JUAN M. CABRERA</u> M.D.	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Transportation</u>			
24B. DATE <u>1/18/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Weavers Funeral Home</u>		24D. LOCATION (City, town, or county) (State) <u>Bristol, Tenn.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		25B. NAME OF REGISTRAR <u>Paul E. Barber</u>		25C. FUNERAL DIRECTOR <u>Paul E. Chenoweth</u>	

SSP-9-008

Union & Independent

Don't say no more

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>PAULINE O'BERRY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 15, 1970</b>		Hour <b>1:55 P.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1742 Gorsuch Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 15, 1970</b>		Hour <b>1:55 P.M.</b>
6. SEX <b>Female</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
9. DATE OF BIRTH <b>6-27-25</b>		10. AGE (In years lost birthday) <b>45</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>?</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>
15. MOTHER'S MAIDEN NAME <b>?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>none</b>
18. INFORMANT <b>Wm. D. Poole</b>		19. ADDRESS <b>1272 Gorsuch Ave.</b>		20. CAUSE OF DEATH <b>Epilepsy</b>
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Barbiturate ingestion</b>		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
24A. DATE OF OPERATION		24B. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) <b>Yes</b>
26A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
26D. TIME (Month) (Day) (Year) (Hour) (Approx.)		26E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26F. HOW DID INJURY OCCUR?
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
28. ACTUAL EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		30. DATE SIGNED <b>January 16, 1970</b>
31A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		31B. DATE <b>1-20-70</b>		31C. NAME OF CEMETERY or CREMATORY <b>Glenn Haven</b>
31D. LOCATION (City, town, or county) (State) <b>A. A. Co.</b>		32A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		32B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>
32C. FUNERAL DIRECTOR <b>Paul E. Chabrowski</b>		32D. ADDRESS <b>3615 Chestnut Ave</b>		

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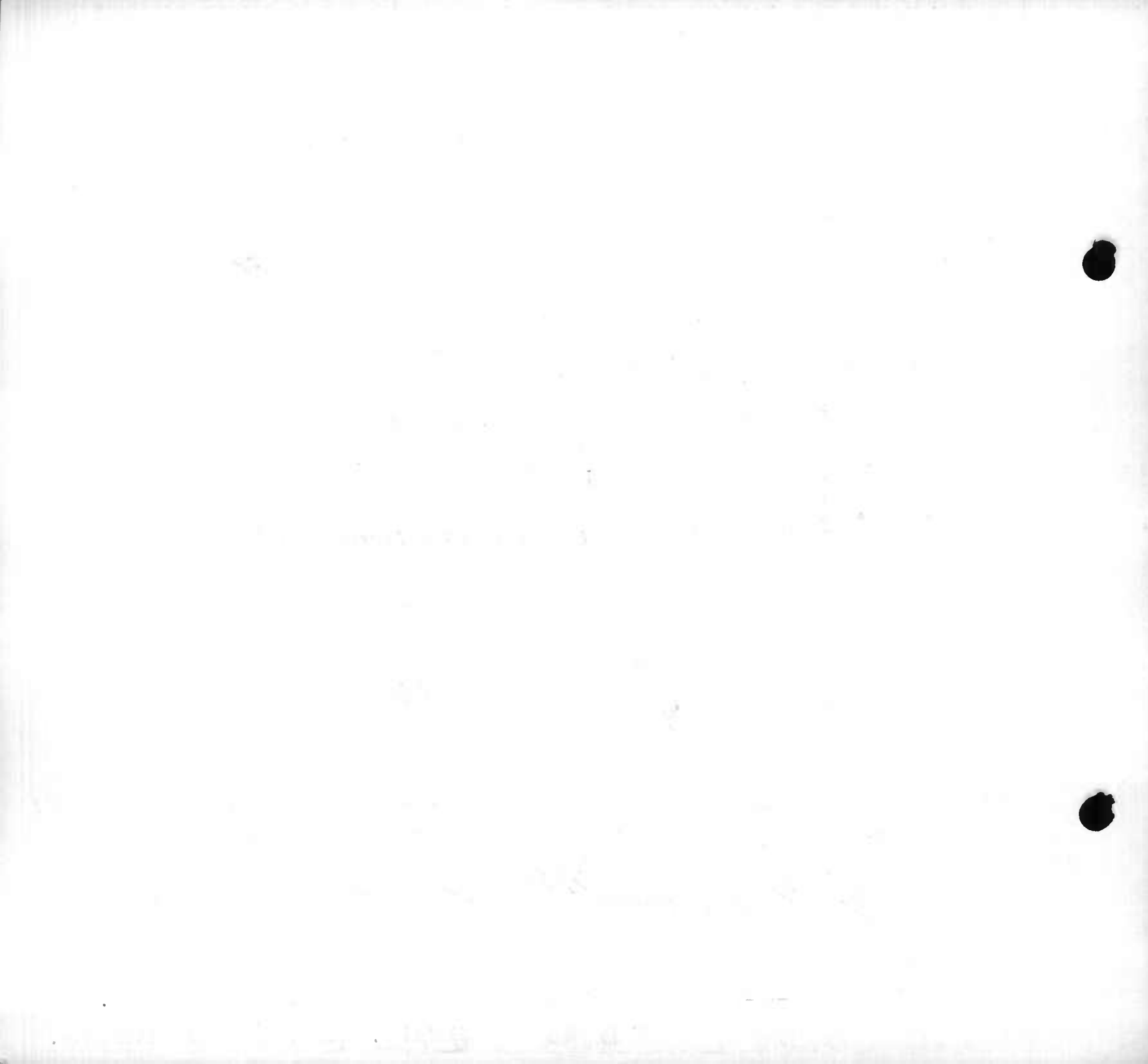
ACADEMY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

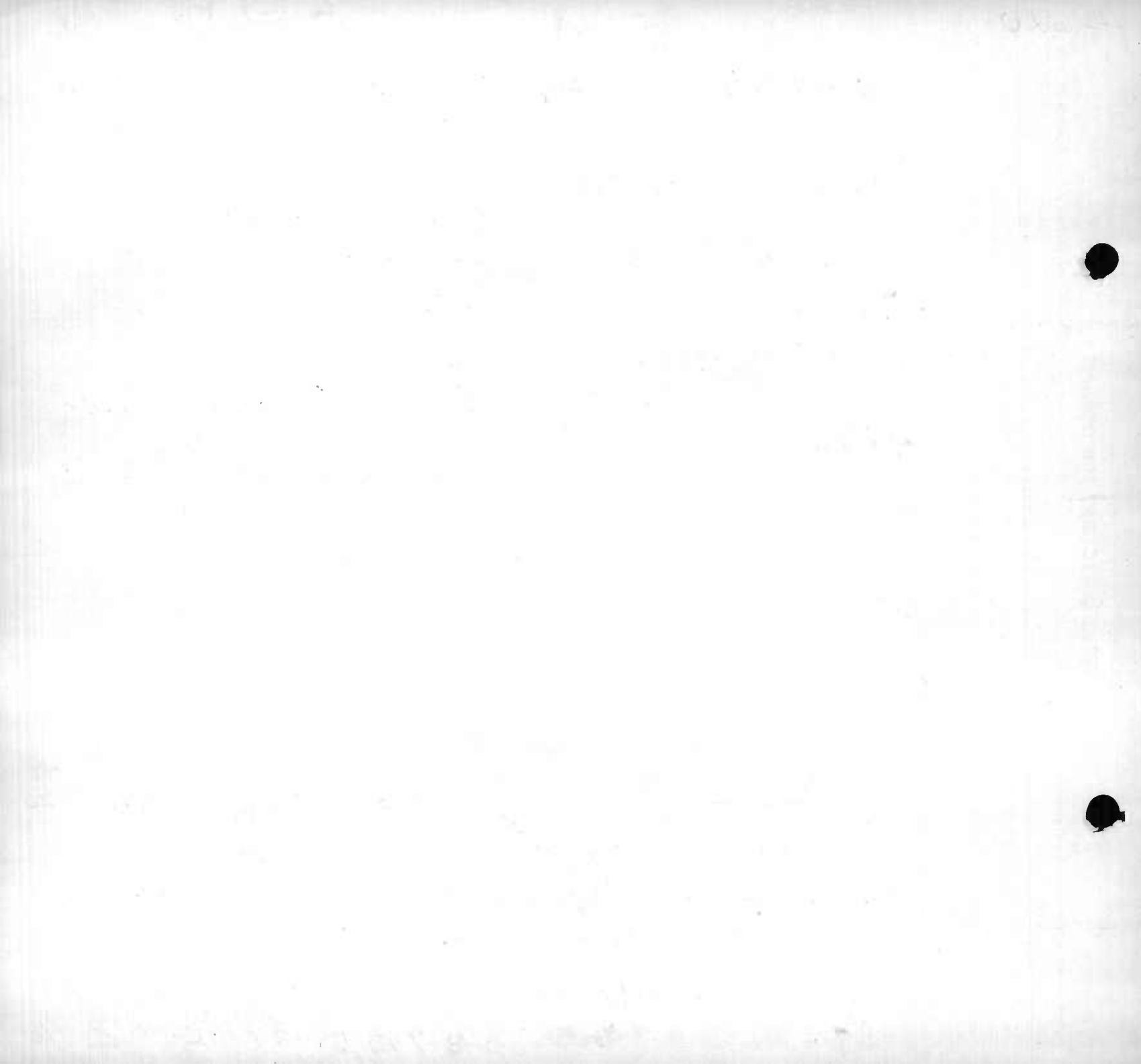
BIRTH NO. 70 00726		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00726	
1. NAME OF DECEASED (Type or Print) <b>IDA V RIDER</b>			2. DATE AND HOUR OF DEATH <b>1-18-70 11:35 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Harford Gardens 4700 Harford Rd</b>			A. STATE <b>Balto. Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>21204</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>724 Morningdale Dr.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1881</b>	9. AGE (In years last birthday) <b>88</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Copenspire</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Cravin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Edwin B. Rider</b>			ADDRESS <b>724 Morningdale Dr. 21204</b>		
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Arteriosclerosis</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>several years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> 19 to <b>Jan</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Jan 17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>1/20/70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Westminister Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Westminister Carroll Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1970</b>			
25B. NAME OF REGISTRAR <b>Thos E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>William E. Johnson 8521 Loch Raven Blvd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00727	
BIRTH NO. 70 00727		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Catherine Elizabeth Harris</i>		2. DATE AND HOUR OF DEATH <i>JAN 15 1970 11 A M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>1306</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>3621 Hickory Ave</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3621 Hickory Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 30 1877</i>	9. AGE (In years last birthday) <i>92</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>James Alfred Gosnell</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Roth Brothers</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Helen E Collison</i>	
18. <i>4.10.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>middle</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>4/15</i> 19 <i>70</i> to <i>1/15</i> 19 <i>70</i> , that (I) <del>(we)</del> lost saw the deceased alive on <i>1/15</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>Reuben Hoffman, M.D.</i>		23B. DATE SIGNED <i>1/16/70</i>		23C. PHYSICIAN'S NAME (Type) <i>REUBEN HOFFMAN MD.</i>	
23D. ADDRESS <i>846 W. 36th St., Baltimore, Md 21211</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>1-19-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Pleasant Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Gamber, Carroll Co Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD.</i>		25C. FUNERAL DIRECTOR <i>Burgee Funeral Home Bldg. Md</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00728	
BIRTH NO. 70 00728		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BURRIER, LILLIAN M.</b>		2. DATE AND HOUR OF DEATH <b>January 16, 1970 8:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4 UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1348</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4018 FALLS ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>05-17-92</b>	9. AGE (In years last birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during last working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>SEWING</b>		<b>Clothing Mfg</b>		<b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES CLAGETT</b>			
14. MOTHER'S MAIDEN NAME <b>GERTRUDE TRIESCHANN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>219221025</b>		17. INFORMANT <b>JOSEPH R. WILSON</b> Same as above.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>495X I</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Y.S.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 30th 1969</b> to <b>January 16th 1970</b> , that (I) (we) last saw the deceased alive on <b>January 16th 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Cabrera K. M.D.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Juan Cabrera M.D.</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville Balto Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Zabo, M.D.</b>		25C. FUNERAL DIRECTOR <b>Burger Funeral Home Balto Md</b>	
				25D. ADDRESS <b>139 Heron Avenue Dr</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00729		REG. NO. 70 00729	
BIRTH NO. 70 00729				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARTHA IRENE SNYDER</b>				2. DATE AND HOUR OF DEATH <b>JANUARY-13TH 1970 2:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1301 W. 41ST. STREET</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-29-08</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MATHEW ZIELINSKI</b>				14. MOTHER'S MAIDEN NAME <b>MARYANN HOANOSKIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES NO NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>HERSELF</b>		ADDRESS	
18. <b>571.9 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Repetitive myocardial infarction for eleven years</b> (B) <b>40% aortic stenosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>M.C.M.</b> (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/15/69</b> to <b>01-13-70</b> that (I) (we) last saw the deceased alive on <b>01-13-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Y. Yamasaki M.D.</b>				23B. DATE SIGNED <b>01-13-70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>YASUNASA YAMASAKI M.D.</b>				23D. ADDRESS <b>33RD AND CALVERT STREET</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-16-70</b>		24C. NAME of CEMETERY or CREMATORY <b>13216 Mt. Vernon Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. J. ...</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>		ADDRESS <b>Baltimore Md</b>	

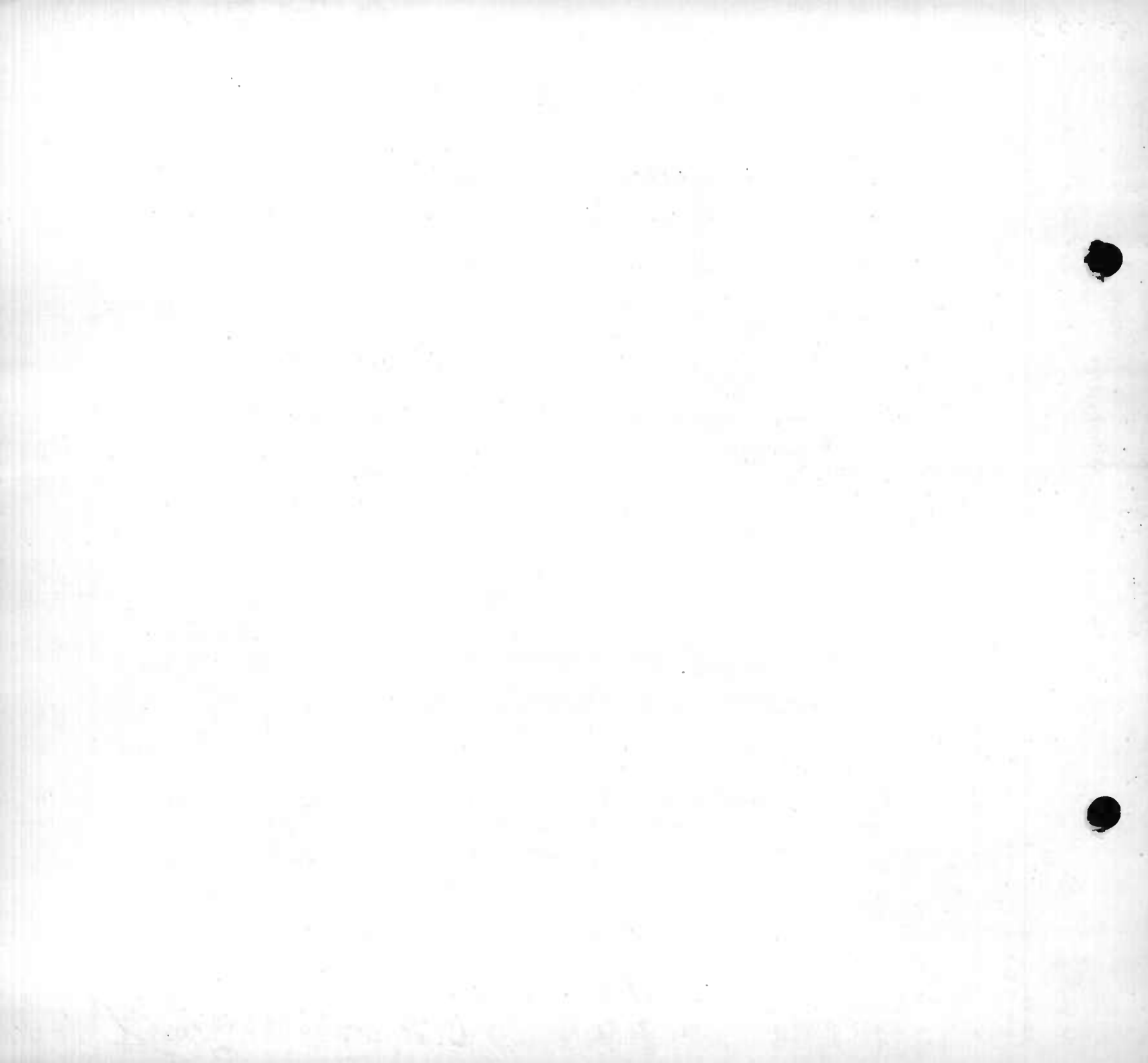
Female home given address as  
1301 W 41st St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00730
70 00730		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Minnie G Standiford</b>		2. DATE AND HOUR OF DEATH <b>JAN 12 1970 8:30 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>2755</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 The Wesley Home</b> <b>2211 W Rogers Ave</b>		C. CITY OR TOWN <b>Betho</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>Jul 20 1880</b> 9. AGE (In years last birthday) <b>89</b>		10. BIRTHPLACE (State or foreign country) <b>Md</b> 11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		13. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
14. FATHER'S NAME <b>William H Smoot</b>		15. MOTHER'S MAIDEN NAME <b>Margaret M Jones</b>		
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213 0168800</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> <b>Ischemic cardiac</b> <b>vascular disease</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>8 September 1969</b> to <b>12 January 1970</b> , that (I) (we) last saw the deceased alive on <b>12 January 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>John W Barnaby</b>		23B. DATE SIGNED <b>15 Jan 70</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOHN W BARNABY</b>		23D. ADDRESS <b>1652 E Redshore Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-16-70</b>		
24C. NAME OF CEMETERY or CREMATORY <b>Mt Olivet Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Betho Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		
25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>		25D. ADDRESS <b>1711 North Mount Vernon St</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 70 00731		
70 00731 CERTIFICATE OF DEATH												
BIRTH NO.												
1. NAME OF DECEASED (Type or Print) <b>JANET L. HADEL</b>					2. DATE AND HOUR OF DEATH <b>JAN 18, 1970 10:35 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>905</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL 33</b>					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
					E. STREET AND NUMBER <b>902 MONTPELIER ST.</b>							
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/21/1937</b>		9. AGE (In years last birthday) <b>32</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ersel Divelbiss</b>					14. MOTHER'S MAIDEN NAME <b>Marguerite Hoffman</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>233-60-3111</b>		17. INFORMANT <b>Mr. Charled D. Hadel</b>			ADDRESS <b>Same</b>		
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SUBARACHNOID HEMORRHAGE</b> (B) (RUPTURED) INTRACRANIAL ANEURYSM DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>prob. unperished</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).												
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>			21C. WHERE DID INJURY OCCUR? <b>—</b>			(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>18 JANUARY 1970</b> to <b>18 JANUARY 1970</b> , that (I) (we) last saw the deceased alive on <b>18 JANUARY 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <b>Karl Stecher, Jr., M.D.</b>					DEGREE			23B. DATE SIGNED <b>19 January 1970</b>				
23C. PHYSICIAN'S NAME (Type) <b>KARL STECHER, JR</b>					DEGREE <b>MD</b>			23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Balto Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>			25C. FUNERAL DIRECTOR <b>Leonard J. Duck Inc.</b>			ADDRESS <b>5305 Harford Rd. 21214</b>			

For the year 1900

W. H. K.

W. H. K.

W. H. K. and the other members of the

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00732</u>	
BIRTH NO. <u>70 00732</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANNETTA A. Wolf</b>		2. DATE AND HOUR OF DEATH <b>January 16, 1970 9:30 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>826 S. Clinton St. 2-11-70</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2611</b>			
5. SEX <b>female</b>		6. RACE <b>caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 23, 1891</b>		9. AGE (In years last birthday) <b>78</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George Dannenfelser</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Yeager</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-36-9857</b>		17. INFORMANT ADDRESS <b>Luther J. Wolf, 1607 Sherwood Ave. Balto.-12</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.31</b> <b>1 Atherosclerotic Heart Disease</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF</b> <b>2 Parkinsonism - Progressive Severe</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF</b> <b>3 Latent Pneumonia</b> <b>(C)</b> <b>II</b> <b>4 Rheumatoid Spinal Stenosis</b> <b>5 generalized arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 15 1960</b> to <b>Jan 16 1970</b> , that (I) (we) last saw the deceased alive on <b>Jan 15 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Donald W. Mintzer</b>		23B. DATE SIGNED <b>Jan 18 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mintzer</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/20/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mr. Carmel - Parkwood Cemetery Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Puck, Inc. - Balto., Md. -14</b>	

V.S. 153

2-11-70

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00733</u>
BIRTH NO. <u>70 00733</u>		1. NAME OF DECEASED (Type or Print) <u>BARBARA M. VIETTEL</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>4 + UNION MEMORIAL HOSPITAL</u>		2. DATE AND HOUR OF DEATH <u>January 18 1970 03:00 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2734</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>11-25-92</u>		9. AGE (in years last birthday) <u>77</u>		If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>FRANCIS MICHAEL</u>		
14. MOTHER'S MAIDEN NAME <u>MARY NOVAK</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>213-03-6436</u>		17. INFORMANT <u>ELDER Mrs. Marie A. Davis</u> Same		
18. <u>189.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of left kidney metastatic</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Exhaustion and retention DR: CHO</u> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>
22. I certify that (I) (this hospital) attended the deceased from <u>January 15 1970</u> to <u>January 18 1970</u> that (I) (we) lost saw the deceased alive on <u>January 18 1970</u> and that (in my) (our) opinion death occurred on the date and hour on from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>C.A. BRAVO</u>		M.D. DEGREE <u>M.D.</u>		23B. DATE SIGNED <u>1/18/70</u>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Puck Inc. 5305 Harford Rd. 21214</u>		

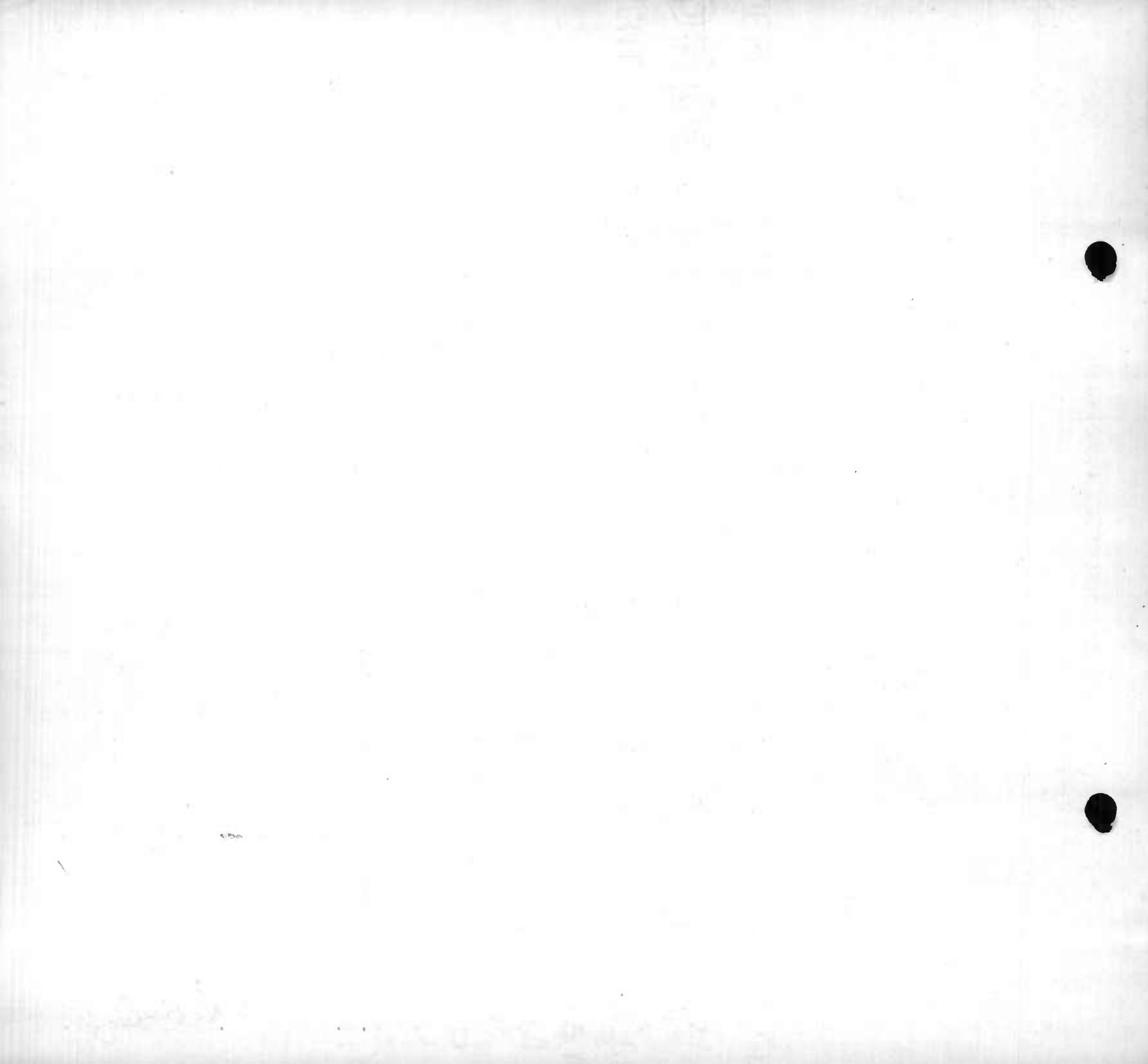




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00734				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00734			
1. NAME OF DECEASED (Type or Print) <u>Arthur French</u>				2. DATE AND HOUR OF DEATH <u>1-18-70</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>1506</u>				5. CITY OR TOWN <u>3218 Westwood Ave</u>				6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
7. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 Lutheran Hospital</u>				8. DATE OF BIRTH <u>3-7-87</u>				9. AGE (In years last birthday) <u>82</u>			
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Della Wilson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-03-1379A</u>				17. INFORMANT <u>Cgristine French</u>			
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma Lung (Rt.)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>pneumothorax Rt.</u>				19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-15-1969</u> to <u>1-18-1970</u> , that (I) (we) last saw the deceased alive on <u>1-18-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>Subash C. Ahuja, M.D.</u>				23B. DATE SIGNED <u>1-18-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>SUBASH C. AHUJA, M.D.</u>				23D. ADDRESS <u>Lutheran Hosp. of Maryland</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/22/70</u>				24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>			
24D. LOCATION <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>				25B. NAME OF REGISTRAR <u>Robert J. ...</u>			
25C. FUNERAL DIRECTOR <u>Kelson F. H.</u>				25D. ADDRESS <u>1348 N. Calhoun St.</u>							



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 00735		70 00735		70 00735	
1. NAME OF DECEASED (Type or Print) <b>Bigham, Emma</b>			2. DATE AND HOUR OF DEATH <b>1-19-70 4:00 p. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b>			6. RACE <b>Negro</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Dec. 25, 1901</b>		
9. AGE (in years last birthday) <b>68</b>			10. Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>George Cooper</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-22-1793</b>		
17. INFORMANT <b>Mr. Charles Bigham (Husband)</b>			ADDRESS <b>Same</b>		
18. <b>450 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>multiple pulm emboli</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1-8-70</b> 19 to <b>1-19-70</b> 19 that (I) (we) last saw the deceased alive on <b>1-19-70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. C. Laredo</b>			23B. DATE SIGNED <b>1-19-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Laredo</b>			23D. ADDRESS <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 24, 70</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>E. J. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>	
25D. ADDRESS <b>1348 N. Calhoun St.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

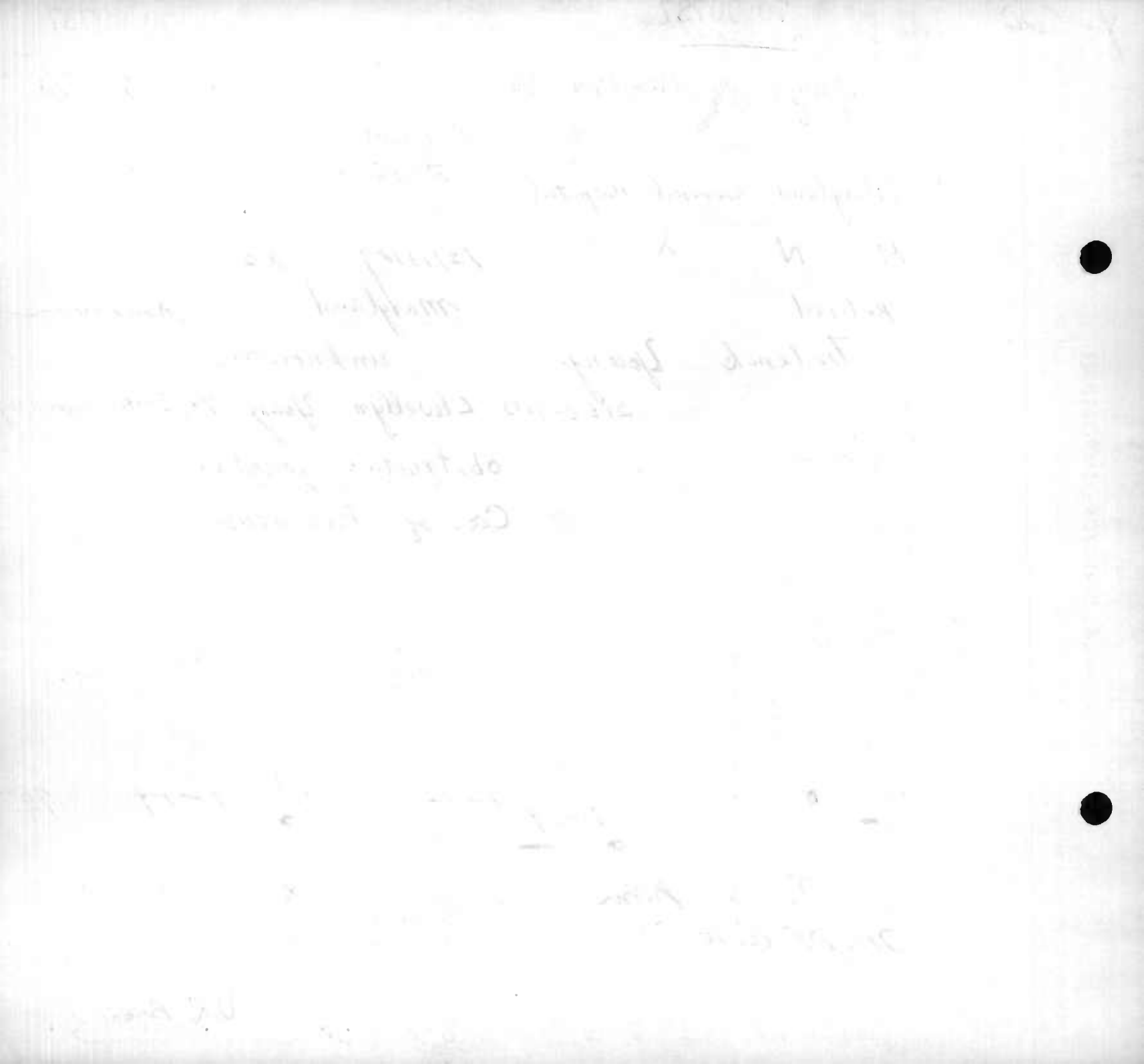
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00736	
70 00736				CERTIFICATE OF DEATH	
BIRTH NO.		70 00736		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Edward Miller		1/18/70 3:45 pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. BALT.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY 2798	
5. SEX M		6. RACE N		C. CITY OR TOWN BALTIMORE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 2, 1900		9. AGE (In years last birthday) 69		E. STREET AND NUMBER 5002 Beaufort Ave	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Mary Miller		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-4109		17. INFORMANT Mary Brooks 5002 Beaufort Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1/5/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerotic disease		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 15 19 69 to Jan 18 19 70 that (I) (we) last saw the deceased alive on Jan 18 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. A. Soliman M.D.		23B. DATE SIGNED Jan 18 1970		23C. PHYSICIAN'S NAME (Type) Joseph Soliman	
23D. ADDRESS SINAI HOSP.		23E. DEGREE		23F. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		24E. CITY, TOWN, or COUNTY		24F. STATE (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1970		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 N. Calhoun St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
70 00737		70 00737		70 00737	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Young, Mr Hamilton W.		1-19-70 7:05/A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
48 Maryland General Hospital		Maryland 1538			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3510 Fairview Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	N	X	12/13/27	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frederick Young		unknown		American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unk		216 037553		Llewellyn Young 947 Brooks Lane 11217	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
157.0 I		obstructive jaundice			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		DUE TO			
		Ca. of Pancrease			
II		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from		1-12-1970 to 1-19-1970			
that (I) last saw the deceased alive on		1-19-1970 and that in (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. S. Kim				1-19-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. S. Kim		827 Linden Av. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/23/70		Arbutus Me. Park	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 22 1970		Robert E. Taylor, MD.		Kelson F.H. 1348 N. Calhoun St.	





T-653

70 00738

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00738

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM JOHN THORNTON</b>					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1023 Wilmot Ct.</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 19 70 2:30 A.M.</b>				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>10 02</b>									
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH <b>July 4, 1893</b>		10. AGE (In years last birthday) <b>76</b>		11. BIRTHPLACE (State or foreign country) <b>Blackstone, Va.</b>		12. CITIZEN OF <b>U.S.A.</b>		E. STREET AND NUMBER <b>1023 Wilmot Ct.</b>	
13. FATHER'S NAME <b>Lee Thornton</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		15. MOTHER'S MAIDEN NAME <b>Mary</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		17. SOCIAL SECURITY NO. <b>288-03-4138</b>	
18. INFORMANT <b>William Thornton Jr.</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) <b>no</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		25. NAME OF REGISTRAR <b>E. Fisher, M.D.</b>		26. FUNERAL DIRECTOR <b>Kelson, F. H.</b>		27. ADDRESS <b>4348 N. Calhoun St.</b>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

**Russell S. Fisher, M.D.**

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**1-19-70**

RECEIVED BY THE

RECEIVED BY THE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CU-420 1

70 00739

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

70 00739

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Wells, Corrine

2. DATE AND HOUR OF DEATH

1-18-70

12:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital, Inc.

1514 Division Street

Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

1120 Riggs Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

6-25-07

9. AGE (in years  
last birthday)

62

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

St. Mary's Ct., Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Dixon

14. MOTHER'S MAIDEN NAME

Mary Barber

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Viola Rogers (Sister)

ADDRESS

Same

18. 410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-10-70 19 to 1-18-70 19  
that (I) (we) last saw the deceased alive on 1-18-70 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Flaredo

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

1-18-70

23C. PHYSICIAN'S  
NAME (Type)

Dr. G. Laredo

23D. ADDRESS

Provident Hospital, Inc.

1514 Division Street - Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/22/70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 22 1970

25B. NAME OF REGISTRAR

Robert E. Stuber, M.D.

25C. FUNERAL DIRECTOR

Kelson, F.A.

1348 N. Calhoun St.



J-525

BALTIMORE CITY HEALTH DEPARTMENT

70 00740

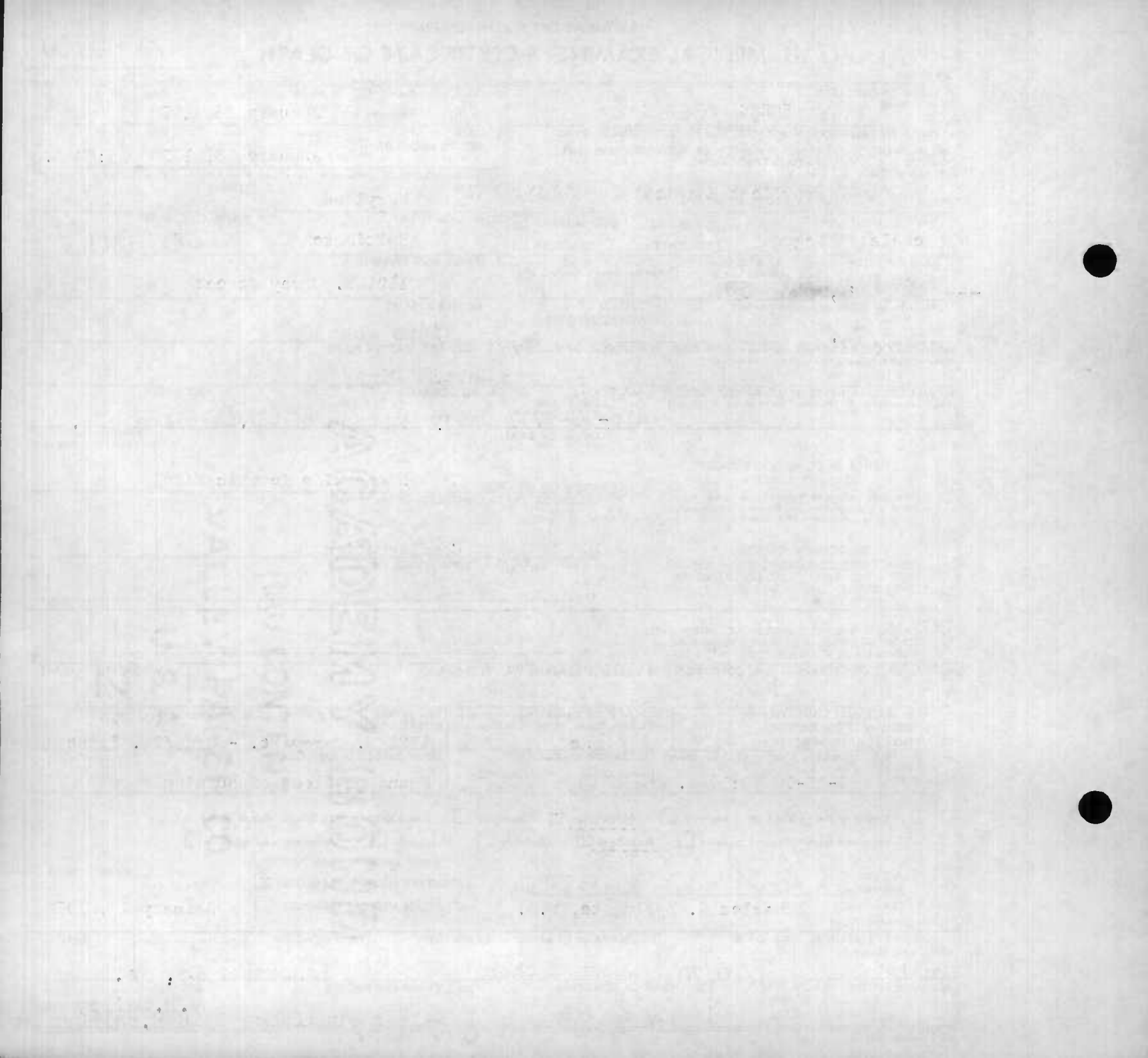
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00740

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Inez IRENE JOHNSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 15, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 15, 1970</b>		Hour <b>5:00 A.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>				
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>May 13, 1911</b>		10. AGE (In years last birthday) <b>58</b>	E. STREET AND NUMBER <b>1121 N. Carey Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME <b>Tidus Johnson</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <b>Hattie Diggs</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>416-09-9737</b>	18. INFORMANT ADDRESS <b>Daisy Johnson 820 N. Caroline St.</b>	
19. <b>E 890 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carbon monoxide intoxication</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Conflagration</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1121 N. Carey St. - 3rd flr. front</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1-15-70 3:14 A. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Found on floor of burning room</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>January 15, 1970</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Queen Esther</b>	24D. LOCATION (City, town, or county) (State) <b>Lancaster Co. Va.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>V. R. Bailey</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kelson Fun!l Home 1348 N. calhoun st</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00741	
BIRTH NO. 70 00741				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>John Winder</u> (JOHNIE E WINDER)		2. DATE AND HOUR OF DEATH <u>1/17/70</u> <u>3:35 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1801</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>38</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>♂</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/24/97</u>		9. AGE (In years last birthday) <u>72</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>aylor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Winder</u> ADDRESS <u>611 Carrollton</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Myocardial Infarction - ASCVD</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Obstructive Pulmonary Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Right Upper lobe lung mass</u> (C) <u>Chronic Peptic Ulcer disease</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Insafely medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>1/17</u> 19 <u>70</u> to <u>1/17</u> 19 <u>70</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>1/17</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <u>did</u> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Richard A. Baum, M.D.</u> DEGREE				23B. DATE SIGNED <u>1/17/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Baum, M.D.</u> DEGREE				23D. ADDRESS <u>University of Maryland Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1/23/70 Burial</u>		24B. DATE <u>1/23/70</u>		24C. NAME OF CEMETERY OF CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>			
25B. NAME OF REGISTRAR <u>R. E. F. J. B. M.D.</u>		25C. FUNERAL DIRECTOR <u>Halstead</u> ADDRESS <u>1206 W North Ave</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00742</u>
BIRTH NO. <u>70 00742</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>WILLIAM H. JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>1-20-70</u> <u>9:10</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2301</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>153 W. Hamburg St.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1889</u>	9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>
13. FATHER'S NAME <u>William Sr. dec'd</u>		14. MOTHER'S MAIDEN NAME <u>Viola dec'd</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Samuel Bethun</u>	
				ADDRESS <u>169 W. Cross St.</u>
18. <u>162.1 I</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory Arrest</u>		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Bronchogenic Car. Rt. Lung (terminal)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>8:30 1-20 1970</u> to <u>9:10 1-20 1970</u> that (I) (we) last saw the deceased alive on <u>9:10 1-20 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Virginia V. Faust, M.D.</u>		23B. DATE SIGNED <u>1-20-70</u>		23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA V. FAUST, M.D.</u>
		23D. ADDRESS <u>South Baltimore General Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>1/24/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Carver Mem Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>	ADDRESS <u>1206 W North Ave</u>	



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BALTIMORE CITY HEALTH DEPARTMENT

70 00743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00743

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LUCYAN KOCH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1742 Aliceanne Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 21, 1970</b>		Hour <b>11:05A.</b>		M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2-03</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. DATE OF BIRTH <b>2/15/07</b>		10. AGE (In years lost birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Antoni Koch</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		
15. MOTHER'S MAIDEN NAME <b>Wanda Karwoska</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-36-5312</b>		18. INFORMANT <b>Mrs. Helen Link, 3 St. Michael's Way</b>
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>571.8 I</b> <b>Fatty Liver</b>		CAUSE OF DEATH <b>Fatty Liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
		(B) DUE TO, OR AS A CONSEQUENCE OF:				
		(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1/21/70</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md. 21222</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>I. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00744</span>	
70 00744				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GUSTAV HENRY JOHANNNS		Jan 17, 1970 1 335 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHN'S HOPKINS HOSPITAL			A. STATE Maryland B. COUNTY 702		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 613 N Belvoir		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1900		9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROLLER		10B. KIND OF BUSINESS OR INDUSTRY SHIP YARD.		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
13. FATHER'S NAME GUSTAV H. JOHANNNS		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II		16. SOCIAL SECURITY NO. 218-01-5393		17. INFORMANT Mrs. Ida S. Lockhart - 4902 Allen Drive Balto. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4/10/9 I Disease or condition directly leading to death CAUSE OF DEATH Cardiac electromechanical dissociation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute myocardial infarction 40 min.		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive pulmonary disease. 1 month		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 8 1970 to Jan 17 1970 that (I) (we) last saw the deceased alive on Jan 17 1970 and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Corey Brown M.D., PH.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) B. COREY BROWN M.D. DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-70		24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEM.	
24D. LOCATION (City, town, or county) (State) BALTO., Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Hastley Miller - 2334 Jefferson St.	
25D. ADDRESS					

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2/4/1907

10. 2. 1907  
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10. 2. 1907

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. 70 00745				
BIRTH NO. 70 00745 1. NAME OF DECEASED (Type or Print) <u>KATHERINE MARIA IRENE</u> <u>BABY GIRL SPELLMAN</u>					2. DATE AND HOUR OF DEATH <u>JANUARY 21, 1970</u> <u>6:42 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>H-2</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7707 MIDDLESEX PLACE</u>				
5. SEX <u>Female</u>		6. RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-70</u>		9. AGE (In years last birthday) <u>0</u> <u>5</u> <u>53-00</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES G. SPELLMAN</u>					14. MOTHER'S MAIDEN NAME <u>HELEN ANASTASKOS</u> <u>7707 Middlesex Rd. #34</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART &amp; Mr. James G. Spellman -</u>			
18. <u>7483 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <u>Cardiorespiratory ARREST</u> <u>2°-ASPIRATION PNEUMONIA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <u>Tracheal Atresia and Tracheo -</u> (B) DUE TO, OR AS A CONSEQUENCE OF:  <u>ESOPHAGEAL FISTULA</u> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>  <u>congenital</u>	
					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HYPERBILIRUBINEMIA</u>			<u>2 days</u>	
19A. DATE OF OPERATION <u>1-17-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TE FISTULA</u>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(this hospital)</u> attended the deceased from <u>birth 1/16/70</u> 1970 to <u>death 1/21/1970</u> that <u>(I) (we)</u> last saw the deceased alive on <u>1/21/1970</u> and that <u>(my) (we)</u> applan death occurred on the date and hour and from the causes stated above. <u>(I) (we) (did) (do not)</u> view the body after death.									
23A. SIGNATURE <u>Edward N. Zisman M.D.</u>					23B. DATE SIGNED <u>1/21/70</u>			23C. PHYSICIAN'S NAME (Type) <u>EDWARD N. ZISMAN</u>	
23D. ADDRESS <u>SINAI HOSP OF BALTIMORE</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-23-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>GREEK ORTHODOX CEM.</u>			24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Nader, M.D.</u>			25C. FUNERAL DIRECTOR <u>Jefferson St.</u>			25D. ADDRESS <u>2334</u>	





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70 00746

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00746

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LOUISE BERNICE SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>CHURCH HOME AND HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1970 10:00 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>604</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>11-17-1918</b>	10. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THEODORE SINES</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE CARSON</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____	
21. DATE OF OPERATION <b>0</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
25. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. HOW DID INJURY OCCUR?			
28. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
29. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
31. DATE SIGNED <b>1/21/70</b>			
32. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		33. DATE <b>1-24-70</b>	
34. NAME OF CEMETERY or CREMATORY <b>OAKLAWN Cem.</b>		35. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
36. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		37. NAME OF REGISTRAR <b>Robert E. Sabey, M.D.</b>	
38. FUNERAL DIRECTOR <b>Walter Hill</b>		39. ADDRESS <b>- 2334 Jefferson St.</b>	

General Land Office  
Washington, D.C.

1-24-75

John A. ...

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00747

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

VIRGINIA LEWIS

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month Day Year  
January 15, 1970

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE  
PRONOUNCED DEADMonth Day Year  
January 15, 1970

Hour

9:20 A.M.

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

CERTIFICATE AMENDED

101 N. Carlton Street  
839 W. Fayette Street

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1801

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7/23/1916

10. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

839 W. Fayette Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Annie Crews

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

215 22 9679

18. INFORMANT

ADDRESS

Annie Crews 871 W. Fayette St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cirrhosis of liver  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 15, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 22 1970

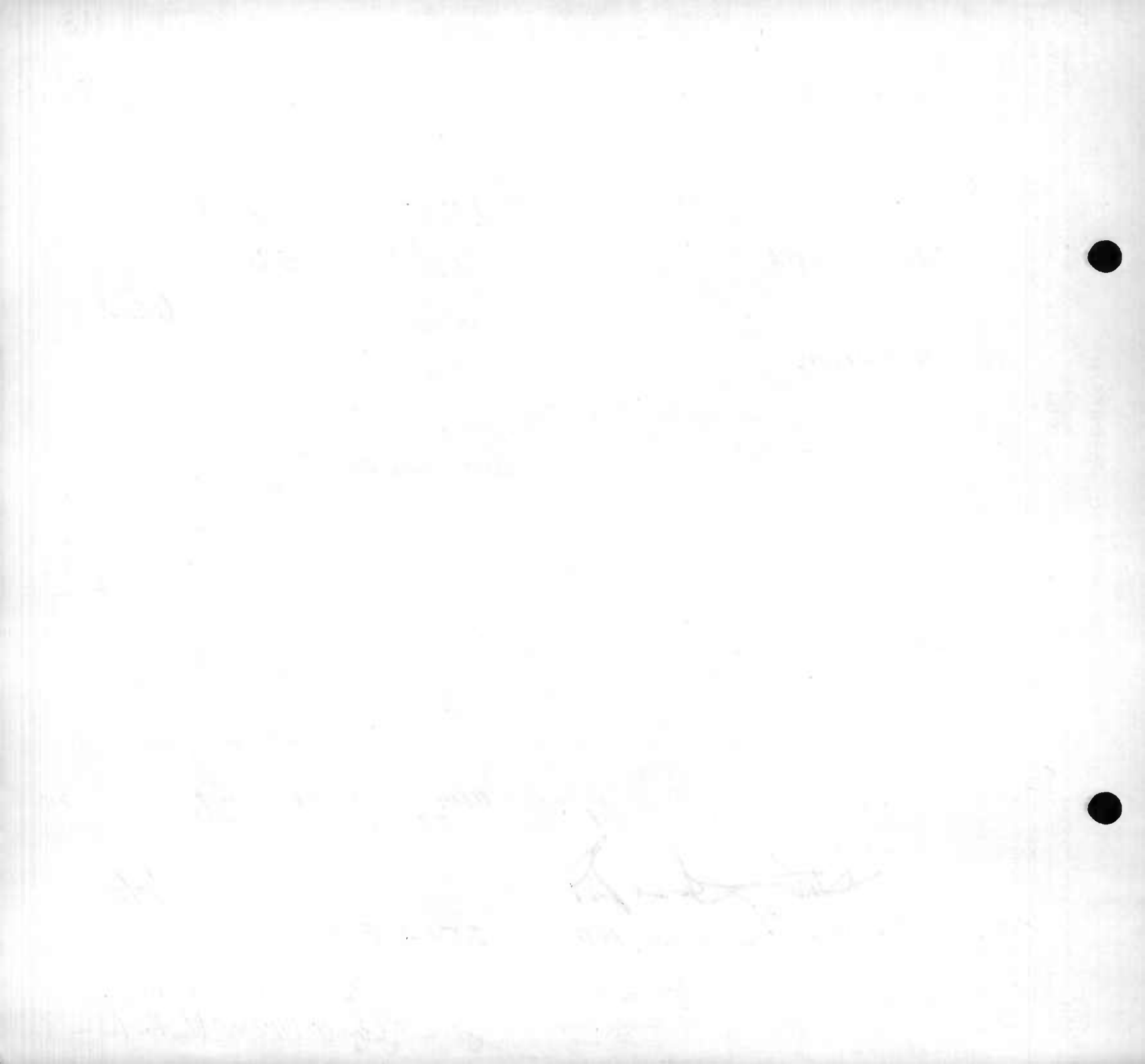
E. J. J. J. J.

1712 W. W. W. W.

Letter from M.F.'s office 2-2-70 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-632

BALTIMORE CITY HEALTH DEPARTMENT				70 00749	
70 00749 CERTIFICATE OF DEATH				REG. NO. 70 00749	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CATHERINE M. FOERTSCHBECK		1-21-70		11 <sup>05</sup> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
18 MARYLAND GEN. HOSPITAL		MARYLAND 2609			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		909 S. CONKLING ST. 21224			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-23-94	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSE WIFE		AT HOME		BALTIMORE, MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE ROCKSTROM		MARY AHLERS		USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		214-01-43710		DAUGHTER - MARIE FOERTSCHBECK - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DIABETES		MELLITUS YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-17 19 70 to 1-21 19 70 that (I) (we) last saw the deceased alive on 1-21- 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
ANGELITA A. TOPACIO		1-21-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ANGELITA A. TOPACIO		Maryland Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1-26-70		SACRED HEART CEM.	
24D. LOCATION		24E. CITY, TOWN, or county		24F. (State)	
7401 GERMAN HILL RD. BA. CO., MD.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 22 1970		Robert E. Fisher, MD.		901 S. CONKLING ST. BALTO., 21224, MD.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-4001		70 00750		BALTIMORE CITY HEALTH DEPARTMENT		70 00750	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>PETER COLEMAN HILL</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 20, 1970 11:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2552</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>303 Seagull Avenue</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/10/13</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PETER HILL</b>				14. MOTHER'S MAIDEN NAME <b>ROSETTA COOK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>ROY HILL</b>	
				ADDRESS			
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC BRONCHITIS, EMPHYSEMA</b> <b>PNEUMONIA, SEIZURE</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY FAILURE</b> (B) <b>CHRONIC BRONCHITIS, EMPHYSEMA</b> (C) <b>PNEUMONIA, SEIZURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>10+ years</b> <b>3 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>JAN. 20, 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RESPIRATORY FAILURE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) <del>(the hospital)</del> attended the deceased from <b>JAN. 20</b> 19 <b>70</b> to <b>JAN. 20</b> 19 <b>70</b> that (1) <del>(we)</del> last saw the deceased alive on <b>JAN. 20</b> 19 <b>70</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Stephen R. Achuff</b> M.D.				23B. DATE SIGNED <b>January 21, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Stephen Achuff, M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/25/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CAMP GROUND</b>		24D. LOCATION (City, town, or county) (State) <b>GREENVILLE CO., VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>CHARLES A. RICE 661 W. BARRETT ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00751	
70 00751				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Caroline S. Bland</u>		2. DATE AND HOUR OF DEATH <u>1-20-70</u> <u>11:00 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1608</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Home</u> <u>90</u>		E. STREET AND NUMBER <u>3601 Gelson Dr.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-85</u>	9. AGE (in years last birthday) <u>84</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Mange Street</u>		14. MOTHER'S MAIDEN NAME <u>MARY STREET</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>24-12-6377</u>		17. INFORMANT <u>Catherine Giles 2023 Cecil Ave.</u>	
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Generalized Arteriosclerosis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yr.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(the doctor)</u> attended the deceased from <u>4-8</u> 19 <u>69</u> to <u>1-20</u> 19 <u>70</u> that <u>she</u> last saw the deceased alive on <u>1-20</u> 19 <u>70</u> and that <u>my</u> <u>our</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>D. C. Alevisatos, M.D.</u>		23B. DATE SIGNED <u>1-20-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>D. C. ALEVISATOS, M.D.</u>		23D. ADDRESS <u>1209 St. Paul St. Balt</u> <u>21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-23-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		25B. NAME OF REGISTRAR <u>Paul C. F. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Randolph J. Collick 9431 E. Oliver St.</u>	



1  
R-200

70 00752

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00752

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
BENJAMIN ROSS		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 20 70 5:35 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
00 926 Carrollton Ave.		Month Day Year Hour January 20, 1970 5:35 a.m.	
6. SEX		7. RACE	
Male		Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS?	
1-2-1923		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday)		E. STREET AND NUMBER	
46		926 Carrollton Ave.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Jacksonville, Florida		U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Isaac Ross			
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Betty Jones		YES	
17. SOCIAL SECURITY NO.		18. INFORMANT	
27-12-8-51		Eric N. Jones	
19. CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		412.2	
Arteriosclerotic and hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
2		YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Tsodore Mihalakis, M.D.		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		Jan 23-1970	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
B Not Cont		Balto. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JAN 22 1970		Robert E. Sabin, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Chas. A. Wilson		on Brumfield A	

*[Handwritten signature]*

B-630

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SAMMIE E. BYRD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 19 70 3:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4557 Reisterstown Rd.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19 1970 3:40 p.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>March 12-38</b>		10. AGE (In years lost birthday) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Therma Simpson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Smith's Dickerson</b>	
15. MOTHER'S MAIDEN NAME <b>Lucille Dickerson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Lucille Dickerson</b>	
19. <b>571.8</b>		CAUSE OF DEATH <b>Fatty liver</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore ;Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-26-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Winston S.C.</b>		24D. LOCATION (City, town, or county) (State) <b>South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Garber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Manigault Home</b>		ADDRESS <b>South Carolina</b>	



TO: THE SECRETARY OF THE ARMY  
FROM: THE CHIEF OF THE ARMY  
SUBJECT: [Illegible]

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1  
D-242

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00754

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES S. DOUGLAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 21 70 9:10 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>16 S. Bond Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 21, 1970 9:10 a.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 5 - 1913</b>		10. AGE (In years last birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jefferson Douglas</b>		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>301</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salmon</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Came Douglas</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>1-26-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Whitman Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Whitman Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>R. E. Faber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Elroy O. Hester</b>		25D. ADDRESS <b>1000 Brantley</b>	

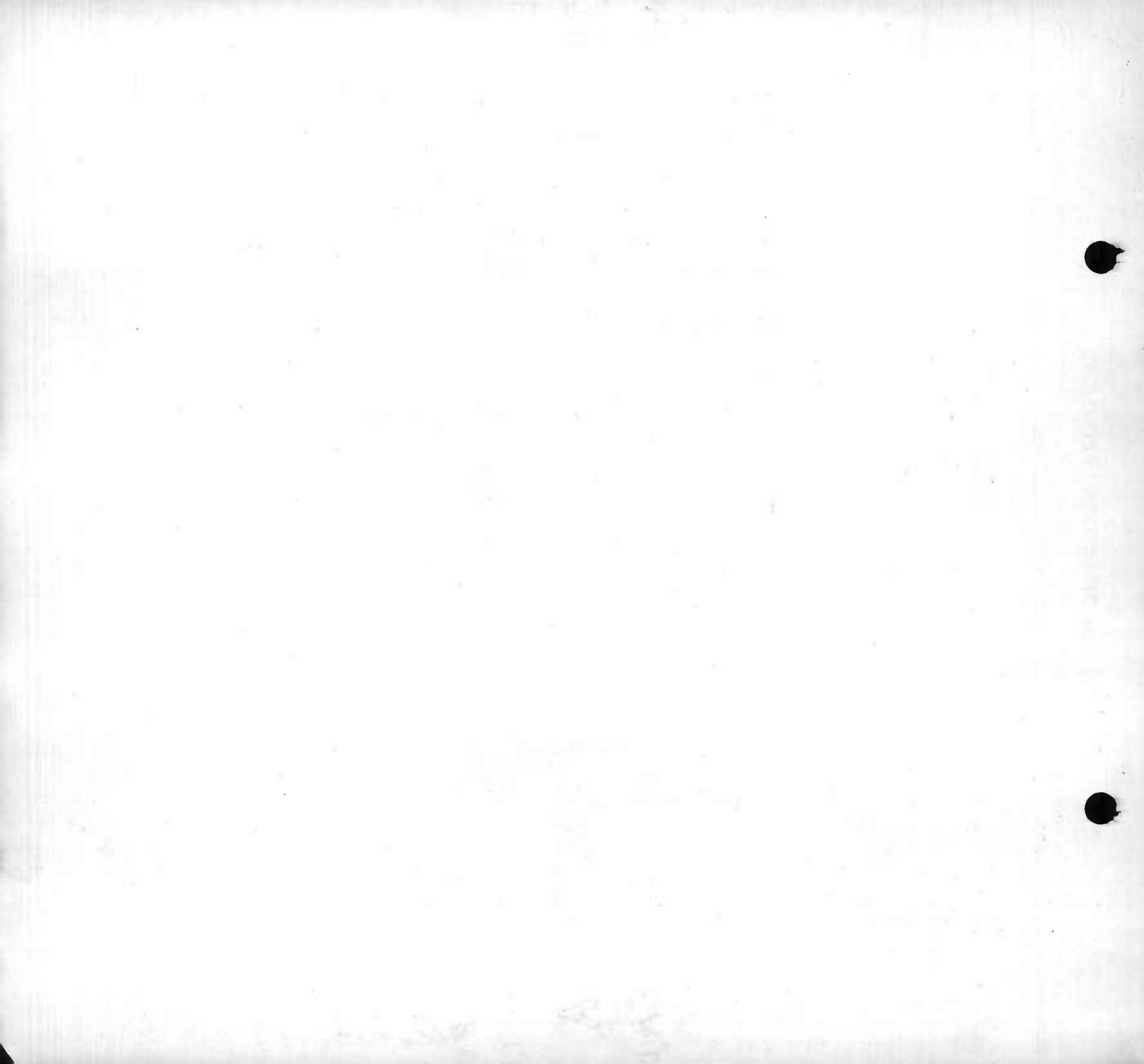
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00755</u>	
BIRTH NO. <u>70 00755</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILSON, MARY</u>		2. DATE AND HOUR OF DEATH <u>1-18-70</u> <u>7 45</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>15 10</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL OF MARYLAND</u>		C. CITY OR TOWN <u>BAITIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>3501 BERWYN AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-13</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-1003</u>		17. INFORMANT <u>Bessie Sulbrack</u> <u>2574 Reisterstown Rd</u>	
18. <u>476X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Bilateral pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bilateral pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1.12.70 to 1.18.70</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Antero-septal myocardial infarction.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (X) (this hospital) attended the deceased from <u>Jan. 12.</u> 19 <u>70</u> to <u>Jan. 18.</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17.</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Nanes</u> <u>MD</u>				23B. DATE SIGNED <u>1.18.70</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. Nanes</u> <u>MD</u>				23D. ADDRESS <u>Lutheran Hosp. Ashburnton St. Balto.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-22-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wheaton Ct Balto</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor, MD.</u>		25C. FUNERAL DIRECTOR <u>Joseph Wilson and Brantly</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00756	
BIRTH NO. 70 00756		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MRS ELIZABETH WARDEN</b>		2. DATE AND HOUR OF DEATH <b>1/18/70 6 20/A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b> <b>2025 W FAYETTE ST.</b> <b>BALTO, MD 21223</b>		A. STATE <b>MD.</b>		B. COUNTY <b>2001</b>	
C. CITY OR TOWN <b>CITY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2003 W. SARATOGA ST, BALTO, MD 21223.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/08</b>	9. AGE (in years last birthday) <b>61</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SC</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13. FATHER'S NAME <b>SAMUEL DOWING</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA WATES.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-3305</b>		17. INFORMANT <b>Marie Lussiter</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>203X I</b>		CAUSE OF DEATH <b>Multiple Myeloma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>(?)</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized</b>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <b>In Baltimore City, give exact location</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/7 1970</b> to <b>1/18 1970</b> that (I) (we) last saw the deceased alive on <b>1/18 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Orathai Thirawat MD</b>				23B. DATE SIGNED <b>1/18/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL, BALTO, MD 23</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Not in line</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		(State) <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Gloria Blush</b>	
25D. ADDRESS <b>1000 Bland St</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00757</u>	
BIRTH NO. <u>70 00757</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Miller, Mary</u>		2. DATE AND HOUR OF DEATH <u>1-20-70</u>   <u>12 Noon</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2542</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3004 Seamon Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1899</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Henry Valentin</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Thomas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>262-26-26684</u>		17. INFORMANT <u>Beatrice (M,S) Daughter</u> ADDRESS <u>Same</u>	
18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>chronic asthmatic bronchitis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>5 days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>5 yrs.</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-1-70</u> 19 to <u>1-20-70</u> 19 that (I) (we) last saw the deceased alive on <u>1-20-70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <u>Dr. C. Laredo</u>		23B. DATE SIGNED <u>1-20-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. C. Laredo</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Crest</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>	
25B. NAME OF REGISTRAR <u>Dr. C. Laredo</u>		25C. FUNERAL DIRECTOR <u>Dr. C. Laredo</u>		25D. ADDRESS <u>1000 Cranberry Ln</u>	

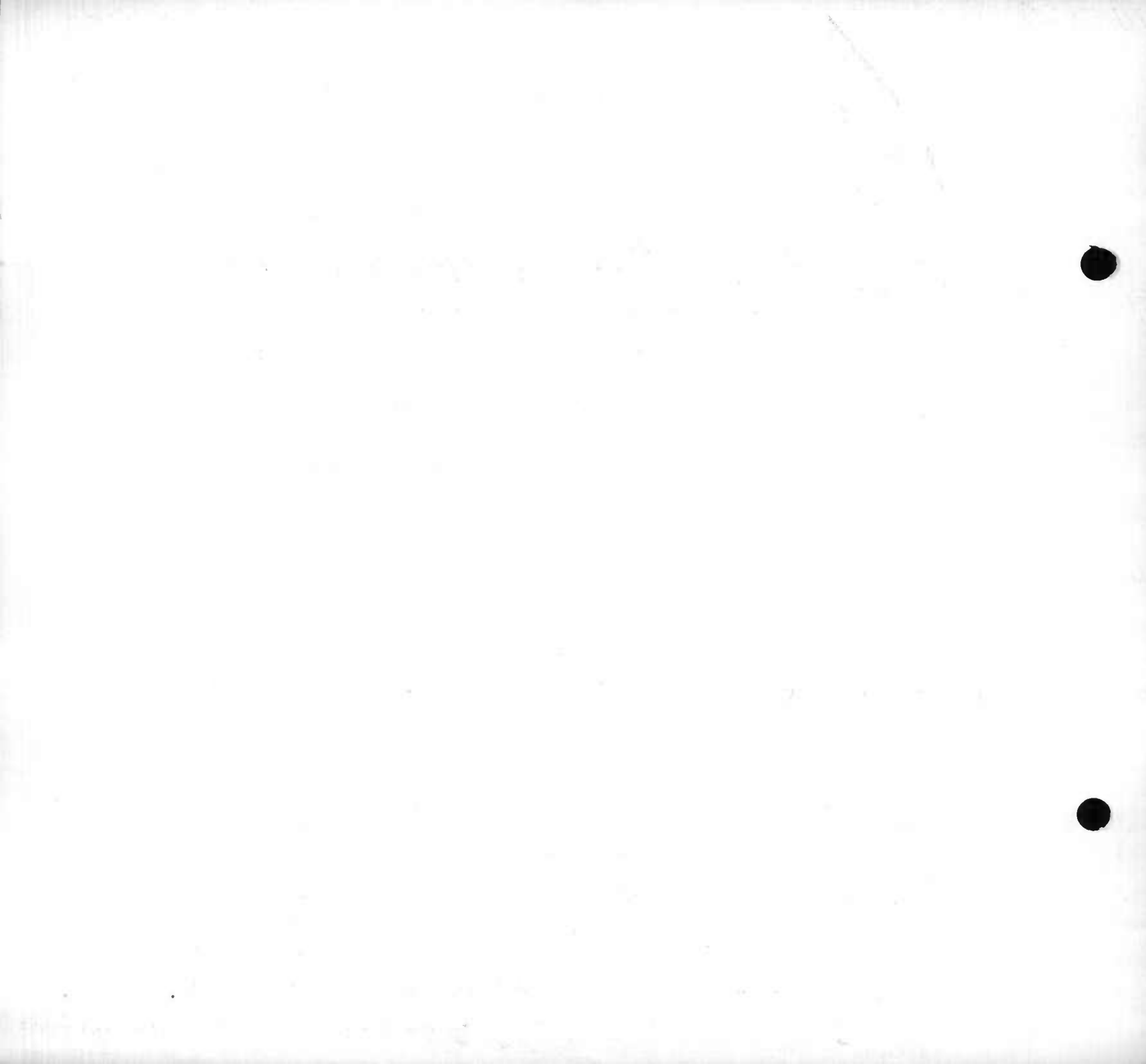




FUNERAL DIRECTOR: IMPORTANT

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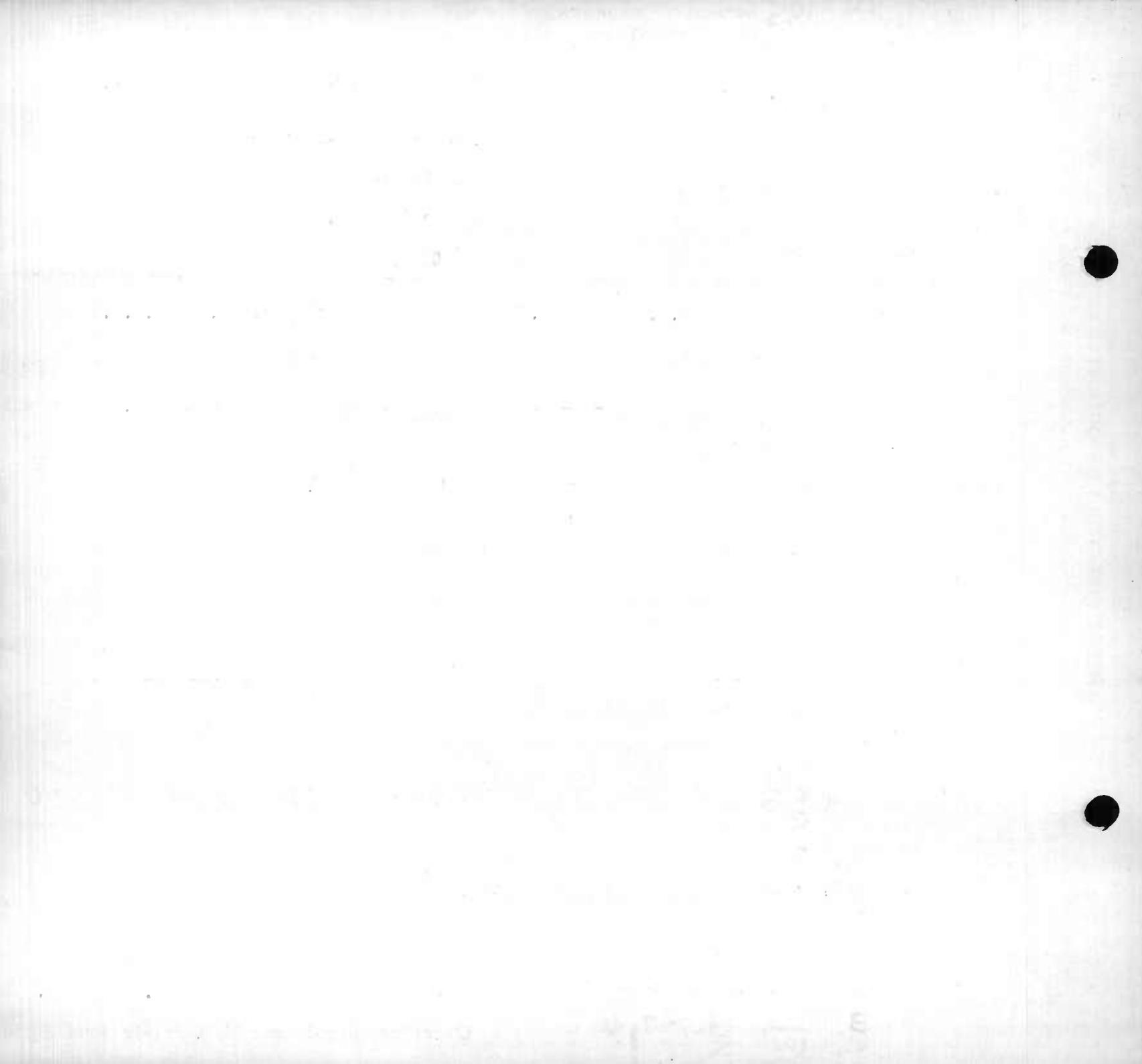
BALTIMORE CITY HEALTH DEPARTMENT				70 00758		X REG. NO.		70 00758	
BIRTH NO.		70 00758		<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>ROSALIE MARCIANTE</b>				2. DATE AND HOUR OF DEATH <b>JAN. 18, 1970 8<sup>10</sup> P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MD HOSP.</b>				A. STATE <b>MD</b>		B. COUNTY <b>BALTO.</b>		5300	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>38</b>				E. STREET AND NUMBER <b>427 OLD HOME RD.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/99</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>JOSEPH COLLETTI</b>				14. MOTHER'S MAIDEN NAME <b>AUGUSTA MARCIANTE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>173-01-0407B</b>		17. INFORMANT <b>HOSP CHART</b>				ADDRESS
18. <b>182.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ADENOCARCINOMA OF ENDOMETRIUM</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>4 YRS.</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (H) (this hospital) attended the deceased from <b>DEC 18 19 69</b> to <b>JAN 18 19 70</b> and that (H) (we) lost saw the deceased alive on <b>JAN 18 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Marvin J. Gordon, M.D.</b>				23B. DATE SIGNED <b>1/18/70</b>					
23C. PHYSICIAN'S NAME (Type) <b>MAVIN J. GORDON, MD</b>				23D. ADDRESS <b>DEPT. OF MEDICINE UNIV. OF MD. HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Fullerton Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Essan Funeral Home</b>		ADDRESS <b>7401 Belair Road 21236</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

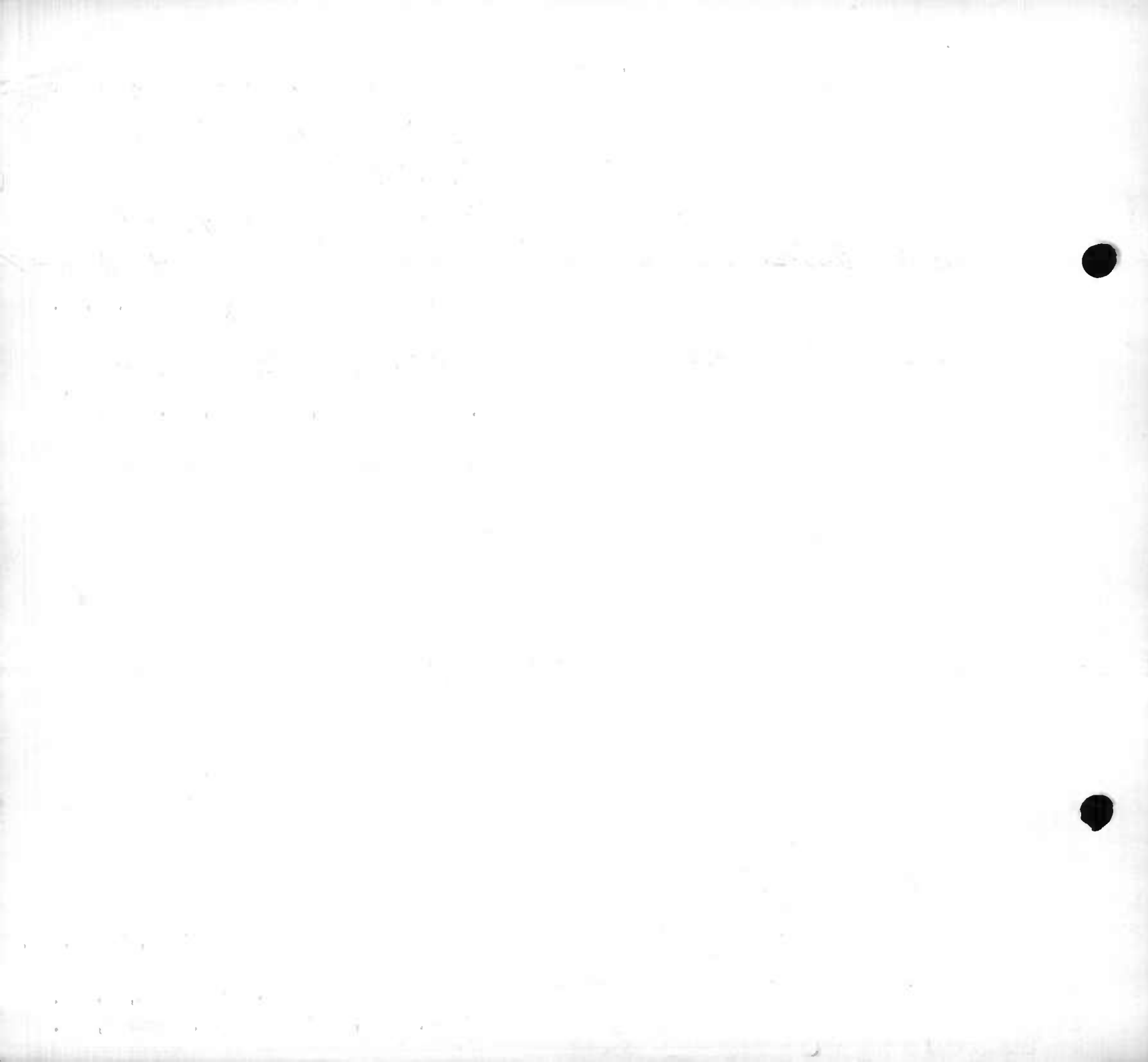
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00759</u>	
BIRTH NO. <u>70 00759</u>		70 00759 <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Charles T. Burton</u>			2. DATE AND HOUR OF DEATH <u>1/17/70</u> <u>1:20</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Edgewood Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>PERRY HALL</u> INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Schroeder Ave.</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/ 83</u>	9. AGE (in years last birthday) <u>87</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>F.S. Royster Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward Burton</u>		
14. MOTHER'S MAIDEN NAME <u>Emma Sims</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>218-03-1143A</u>			17. INFORMANT <u>Mrs Babina Parlett Schroeder Ave. Perry Hall</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOGENIC CARCINOMA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> <u>1964</u> to <u>1/17</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Berger MD</u>				23B. DATE SIGNED <u>1/17/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>B. Berger</u>				23D. ADDRESS <u>Perry Hall Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-21-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Perry Hall Meth Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Perry Hall Balto. Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 23 1970</u>			
25B. NAME OF REGISTRAR <u>E. J. Kelly, Reg. 000</u>		25C. FUNERAL DIRECTOR <u>Classam Funeral Home</u>			
ADDRESS <u>7401 Belair Road 21236</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 00750 4	
BIRTH NO. 70-0084370 00760				<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY FORTNEY Y</b>				2. DATE AND HOUR OF DEATH <b>1-18-70 5:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hospital</b>				A. STATE <b>Md.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>1614 Four Georges Ct. Apt. 4A</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/70</b>	9. AGE (In years last birthday) <b>1</b>	10. Under 1 Yr. Months <b>1</b>	11. Under 24 Hrs. Days <b>2</b>	12. Under 55 Min. <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Larry Fortney</b>				14. MOTHER'S MAIDEN NAME <b>Linda Haruley</b> mother <b>Same</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Father) <b>Mr. Larry Fortney, Dundalk, Md. 21222</b>		
18. <b>776.21</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <b>RESPIRATORY DISTRESS SYNDROME</b>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <b>PREMATURITY</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-17-70</b> to <b>1-18-70</b> that (I) (we) last saw the deceased alive on <b>1-18-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>U. Sangrum</b>				23B. DATE SIGNED <b>1-18-70</b>		23C. PHYSICIAN'S NAME (Type) <b>U. SANGRUM</b>	
23D. ADDRESS <b>MGM. Maryland General Hospital, Balto. Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lions Club Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Harrison Co. Lumberport, W. Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 22 1970</b>		25B. NAME OF REGISTRAR <b>John P. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

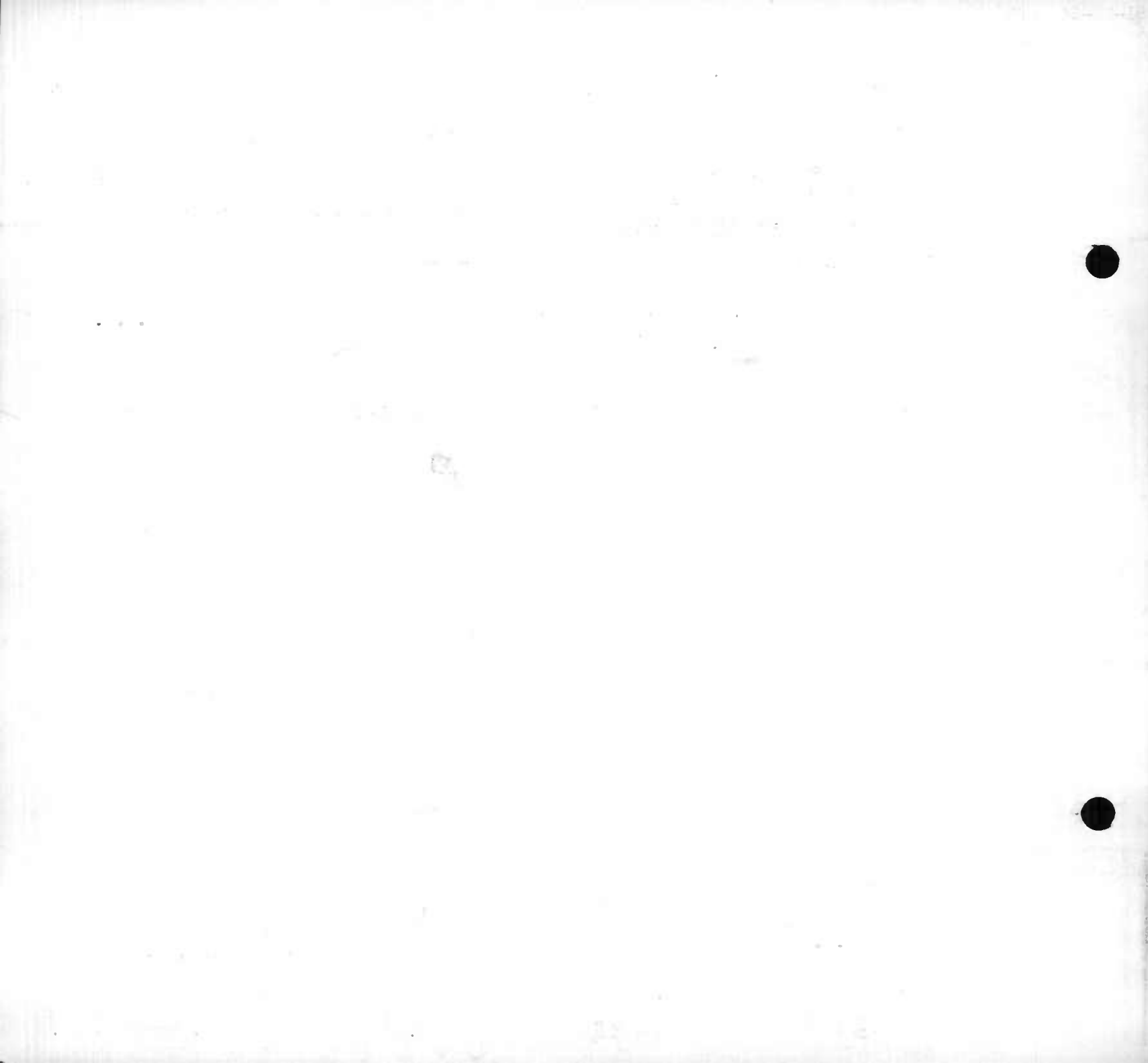
70 00761

## CERTIFICATE OF DEATH

REG. NO.

70 00761

BIRTH NO.		70 00761		2. DATE AND HOUR OF DEATH		1/19/70 3:55 A.M.	
1. NAME OF DECEASED (Type or Print) <b>Norbert P. Schaefer</b> <b>Norbert Peter Schaefer</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>11-26-1922</b>		9. AGE (In years last birthday) <b>47</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Traffic Mgr.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Stephen J. Czerwinski</b>				14. MOTHER'S MAIDEN NAME <b>Rose Rosinski</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>216-16-0705</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>aspiration</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>10 days</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>1/6/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Return of tube flap, pneumonia</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> 19 <b>70</b> to <b>1/19</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/19</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. T. Holliday, M.D.</b>				23B. DATE SIGNED <b>1/19/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>M.T. HOLLIDAY</b>				23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 00762</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="float: right;">70 00762</span>	
1. NAME OF DECEASED (Type or Print) <i>Katherine M. Boggs</i>			2. DATE AND HOUR OF DEATH <i>1-15-70</i> <span style="float: right;">1 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>37 Mercy Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Baltimore County, Maryland</i> B. COUNTY <i>53-00</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <i>518 Windwood Rd.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>9-12-00</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired School teacher Education</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>George Marsh</i>			14. MOTHER'S MAIDEN NAME <i>Caroline Steiger</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>214-40-4987</i>		17. INFORMANT <i>Carolyn Morgan</i>
			ADDRESS <i>3313 Glenside Drive</i>		
18. <i>410.94 1250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>A.S.C.H.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hrs.</i> <i>years.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<i>Diabetes Mellitus; Suspected metastatic Ca 7 Years.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Philip H. Moore M.D.</i> DEGREE				23B. DATE SIGNED <i>1-15-70</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Mercy Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/19/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>	
24D. LOCATION <i>Woodlawn Balto. Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		24F. NAME OF REGISTRAR <i>2468-720-040</i>	
24G. FUNERAL DIRECTOR <i>Michael J. Wiedefeld</i>		24H. ADDRESS <i>Home 6500 York Rd</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00763				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00763	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>James H. Brophy, Sr.</u>				2. DATE AND HOUR OF DEATH <u>Jan. 16, 1970 11:15 A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u>		B. COUNTY <u>Baltimore City</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3100 St. Paul St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10, 1893</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Brophy</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Hanna Montes</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-49234</u>		17. INFORMANT <u>Mr. James Brophy, Jr.</u>		ADDRESS <u>703 Hollen Rd. Balto, Md. 21212</u>	
18. <u>207.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> <u>Infected Bruises</u> (B) <u>Congestive Heart Failure; Atrial Fib</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Leukemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>12 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>at</u> (this hospital) attended the deceased from <u>1-16-1970</u> to <u>1-16-1970</u> that (I) <u>was</u> last saw the deceased alive on <u>1-16-1970</u> and that (in my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. P. Mikus</u>				23B. DATE SIGNED <u>1/16/70</u>		23C. PHYSICIAN'S NAME (Type) <u>J. P. Mikus</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>1/19/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. F. B. D. M. D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> ADDRESS <u>6500 York Rd. Balto.</u>			

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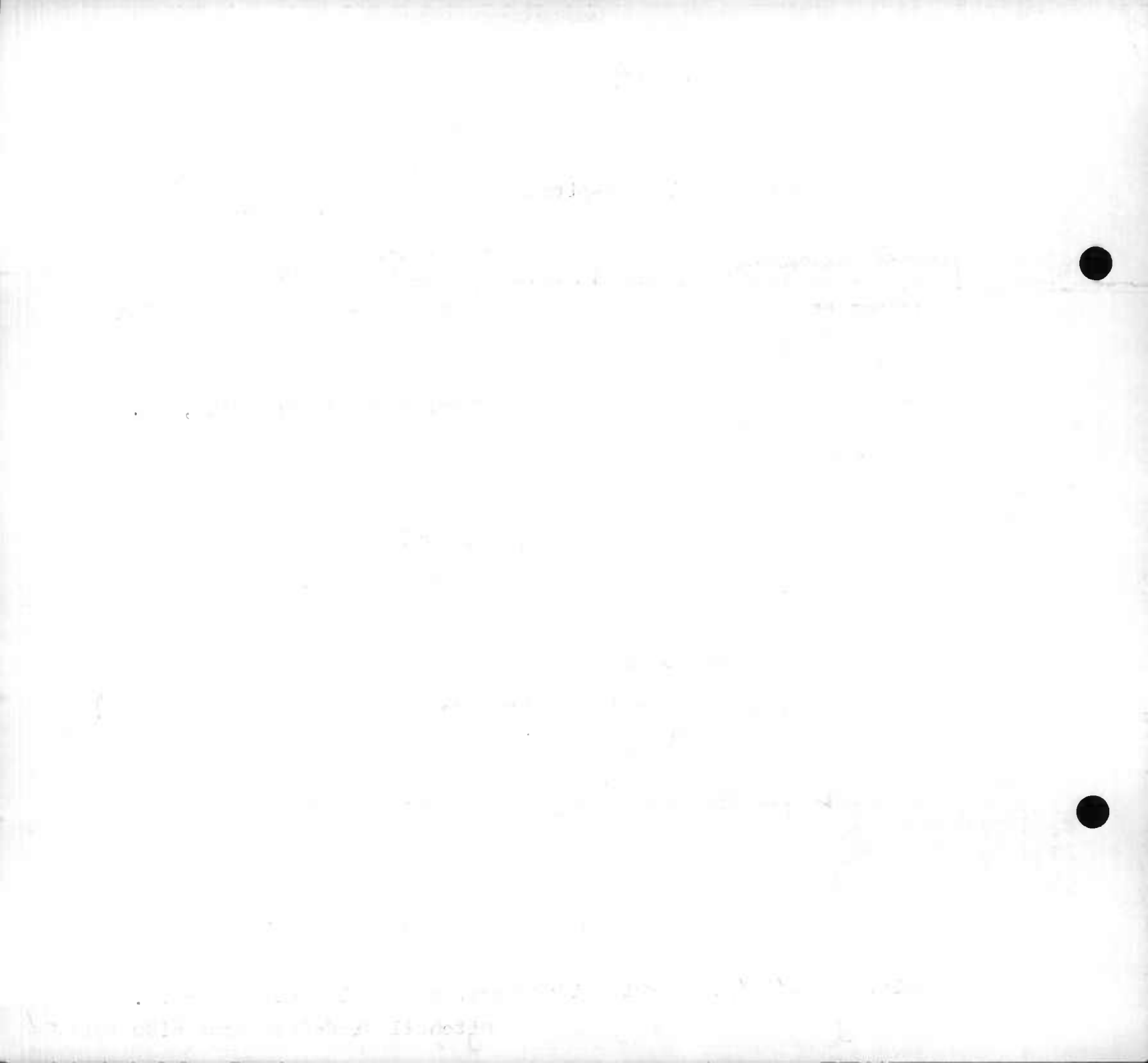
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

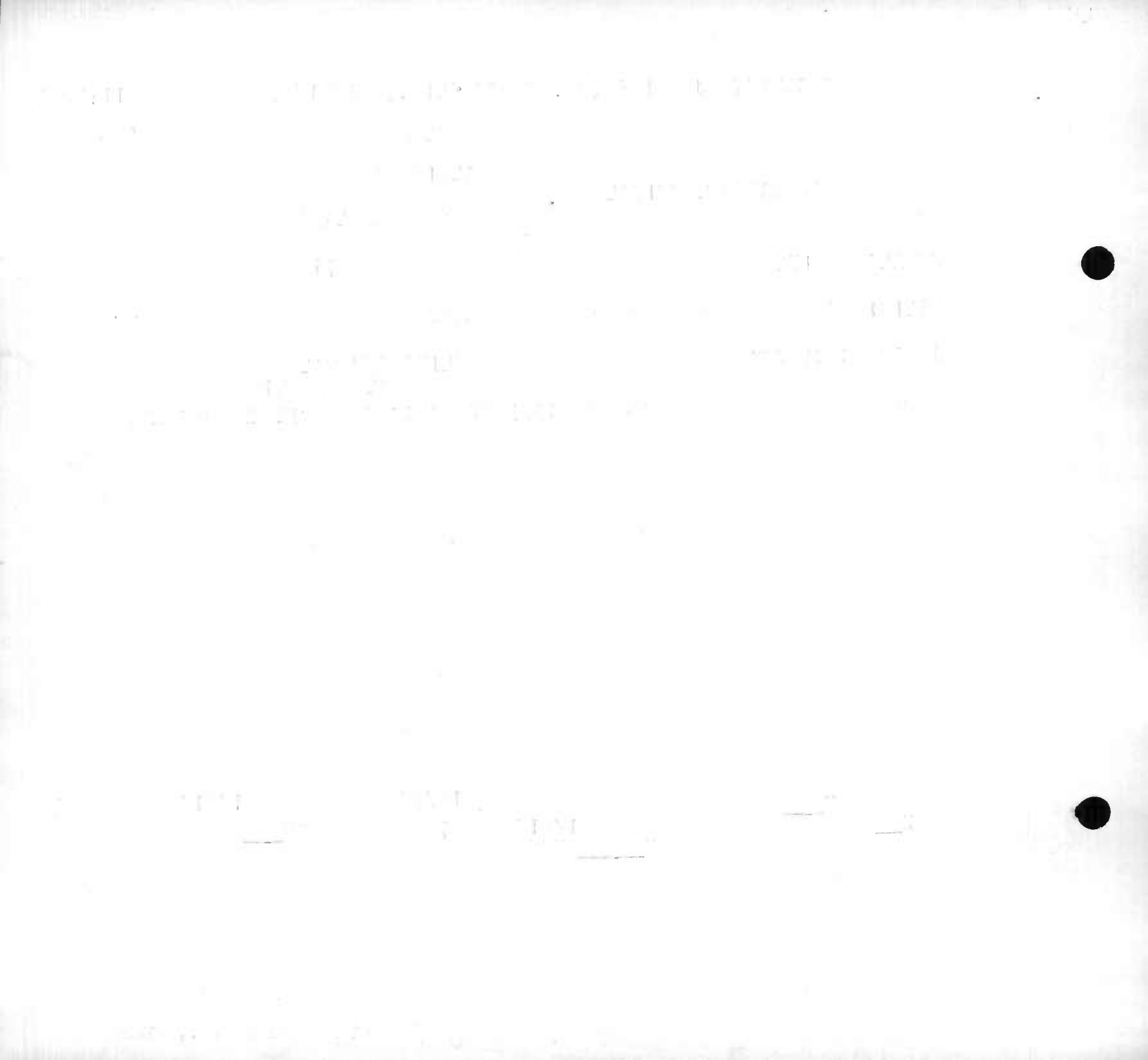
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00764	
70 00764 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Helen Mary Tate</i>		2. DATE AND HOUR OF DEATH <i>1/18/70 11:55 pm</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>44 Union Memorial Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1203</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2822 N. Calvert Street</i>		
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-13-90</i>	9. AGE (In years last birthday) <i>79</i>	10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Joseph Tate</i>			14. MOTHER'S MAIDEN NAME <i>Emily Hooper</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Charles Weant Annapolis, Md.</i>	
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>(B) Carcinomatous</i> DUE TO, OR AS A CONSEQUENCE OF: <i>(C) congestive heart failure.</i>		
19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>AM</i> (this hospital) attended the deceased from <i>12-06-69</i> 19 <i>69</i> to <i>1/18</i> 19 <i>70</i> that <i>AM</i> (we) last saw the deceased alive on <i>1/18</i> 19 <i>70</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>DP. van KAMMEN MD</i>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>DP. van KAMMEN MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>1/21/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Pikesville Balto. Md</i>			25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		
25B. NAME OF REGISTRAR <i>John E. Taylor MD</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Mitchell Wiedefeld Home 6500 York Rd.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00765</u>	
BIRTH NO. <u>70 00765</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>MC CARTHY, JUSTINE (SR. JAMES ELIZ.)</u>		2. DATE AND HOUR OF DEATH <u>1/21/70</u> <u>11:40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>40</u> <u>ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2834</u>			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>ST AGNES HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>600 COOKS LANE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 26 98</u>	9. AGE (in years last birthday) <u>71</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RELIGIOUS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sister in Convent</u>		11. BIRTHPLACE (State or foreign country) <u>MASS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES MC CARTHY</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH WALDRON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>216 54 1333</u>		17. INFORMANT <u>BALTO MD 21229</u> ADDRESS <u>ST AGNES HOSP WILKENS &amp; CATON</u>			
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASPIRATION PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ADENOCARCINOMA OF THE COLON WITH MASSIVE ABDOMINAL METASTASIS.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12-24 H.</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>JAN/19/1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA OF THE COLON</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>12/26</u> <u>1969</u> to <u>1/21/</u> <u>1970</u> that <u>(X)</u> (we) last saw the deceased alive on <u>1/21/</u> <u>1970</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Julio Freijanes M.D.</u>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/21/70.</u>	
23C. PHYSICIAN'S NAME (Type) <u>JULIO FREIJANES M.D.</u>		23D. ADDRESS <u>ST. AGNES HOSPITAL</u> <u>1000 CATON AVE., BALTO 21229.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., 21229</u>			

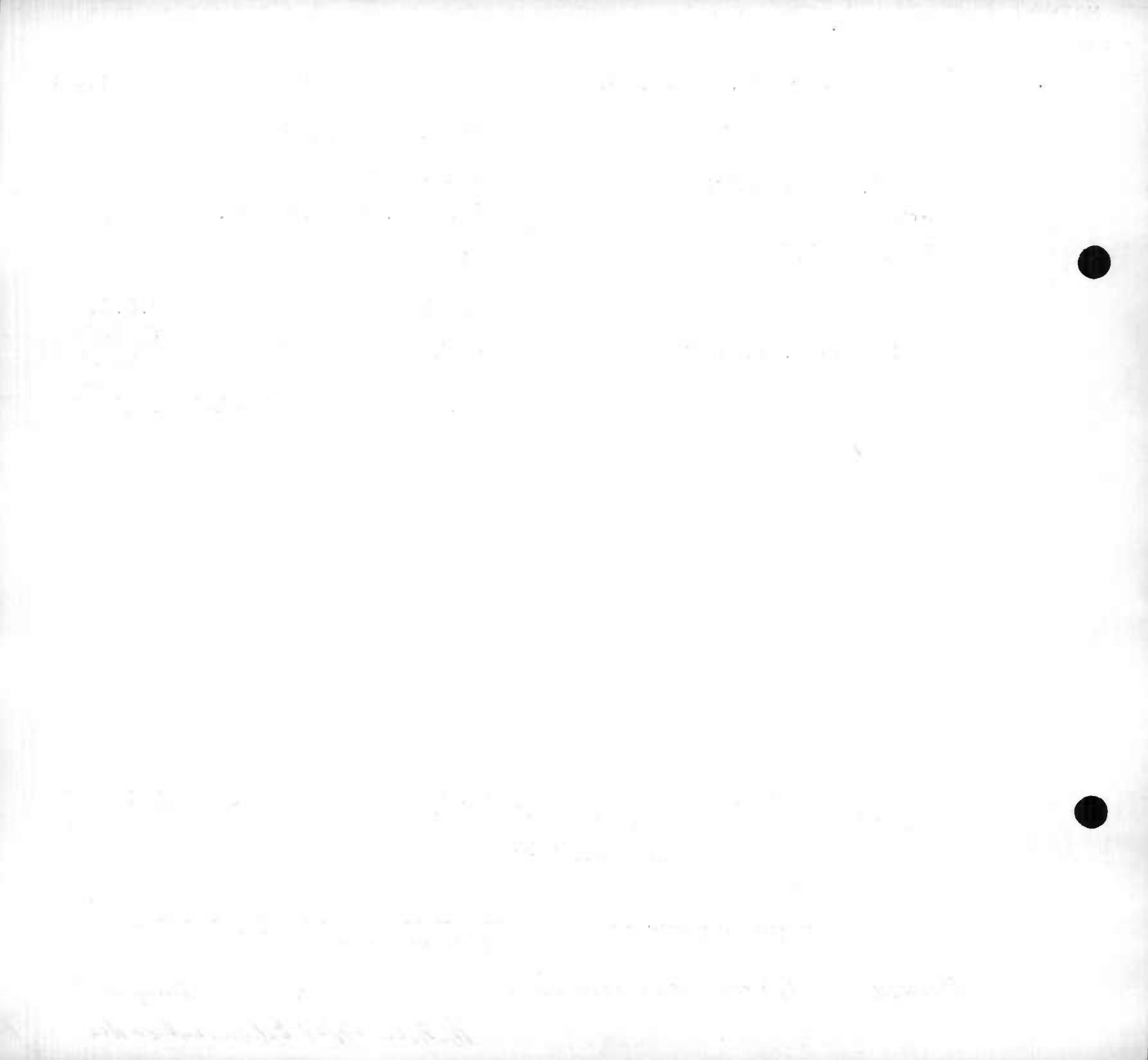




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		X REG. NO. 70 00766	
BIRTH NO. 70-01205 70 00766				1. NAME OF DECEASED Type or Print		2. DATE AND HOUR OF DEATH 01/17/70 11:00A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY (BALTIMORE) 5300			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/17/70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 6 45		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HERMAN D. SIZEMORE				14. MOTHER'S MAIDEN NAME EVELYN (HUBBARD)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS BALTO MD 21229			
18. 740.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Encephalitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 45 min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 17 1970 to JANUARY 17 1970 that (I) (we) last saw the deceased alive on JANUARY 17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
23A. SIGNATURE Krita Apibumyopas MD				23B. DATE SIGNED 1/20/70			
23C. PHYSICIAN'S NAME (Type) KRITA APIBUMYOPAS				23D. ADDRESS ST AGNES HOSP WILKENS & CATON BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/70		24C. NAME of CEMETERY or CREMATORY Londonderry Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1970		25B. NAME OF REGISTRAR Deane F. ...		25C. FUNERAL DIRECTOR Edmondson		ADDRESS	



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BALTIMORE CITY HEALTH DEPARTMENT

70 00767  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00767

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCIS BUNJON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 17, 1970</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b> (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 17, 1970 4:50 P. M.</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>903</b>
9. DATE OF BIRTH <b>Dec. 12, 1921</b>	10. AGE (In years last birthday) <b>48</b>	11. BIRTHPLACE (State or foreign country) <b>Phila., Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Ambassador Pharm.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-14-947</b>	
18. INFORMANT <b>Mr. John F. Bunjon (husband)</b>		ADDRESS <b>Bridget McGowan</b>	
19. <b>412.4</b> CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 18, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/21/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. Jaffee, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		ADDRESS <b>6500 York Rd. 21212</b>	

RECORDS OF THE DEPARTMENT OF THE ARMY

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ADJUTANT GENERAL'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00788		CERTIFICATE OF DEATH		REG. NO. 70 00788	
BIRTH NO.		70 00788		2. DATE AND HOUR OF DEATH		1-19-70 8:45 A.M.			
1. NAME OF DECEASED (Type or Print) HOLLOWAY, HELEN B				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY BALTIMORE 1102	
5. SEX FEMALE				6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-23-94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK H. HOLLOWAY				14. MOTHER'S MAIDEN NAME HESSIE BOUNDS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-14-4645A				17. INFORMANT Fred H. Holloway 8 Meadow Rd. Balto. Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD, ATRIAL FIB. CHF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GI HEMORRHAGE				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) INT. HEMORRHAGIC TELEANGIECTASIA					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ESOPHAGEAL-HERNIA INVERTICULIN									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 1-19-69 1970 to 1-19 1970		that (I) (we) last saw the deceased alive on 1-19-1970		and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. MIKUS				23B. DATE SIGNED 1-19-70					
23C. PHYSICIAN'S NAME (Type) J. P. MIKUS				23D. ADDRESS UMH					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1/21/70		24C. NAME OF CEMETERY or CREMATORY Mardella Memorial Cem.		24D. LOCATION (City, town, or county) (State) Mardella Springs, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 22 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 00769

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOUISE W. SCHLAICH

2. DATE AND HOUR OF DEATH

11/19/70

12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MD.

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2643 WILKENS AV.

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

9/8/91

9. AGE (in years last birthday)

78

10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

BALTO.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John

WENTZ

~~REDACTED~~

14. MOTHER'S MAIDEN NAME

Louisa Reiner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-26-5780

17. INFORMANT

Arbutus, Md. 21227

ADDRESS

Mrs. Harvey VonHarten 1026 Elm Rd.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

EVA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

diabetes mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/18/70 to 11/19/70 that (I) (we) last saw the deceased alive on 11/19/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*[Signature]*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/19/70

23C. PHYSICIAN'S NAME (Type)

RAFAEL LEVITES, MD

23D. ADDRESS

Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Jan. 22, 1969

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Cem.

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

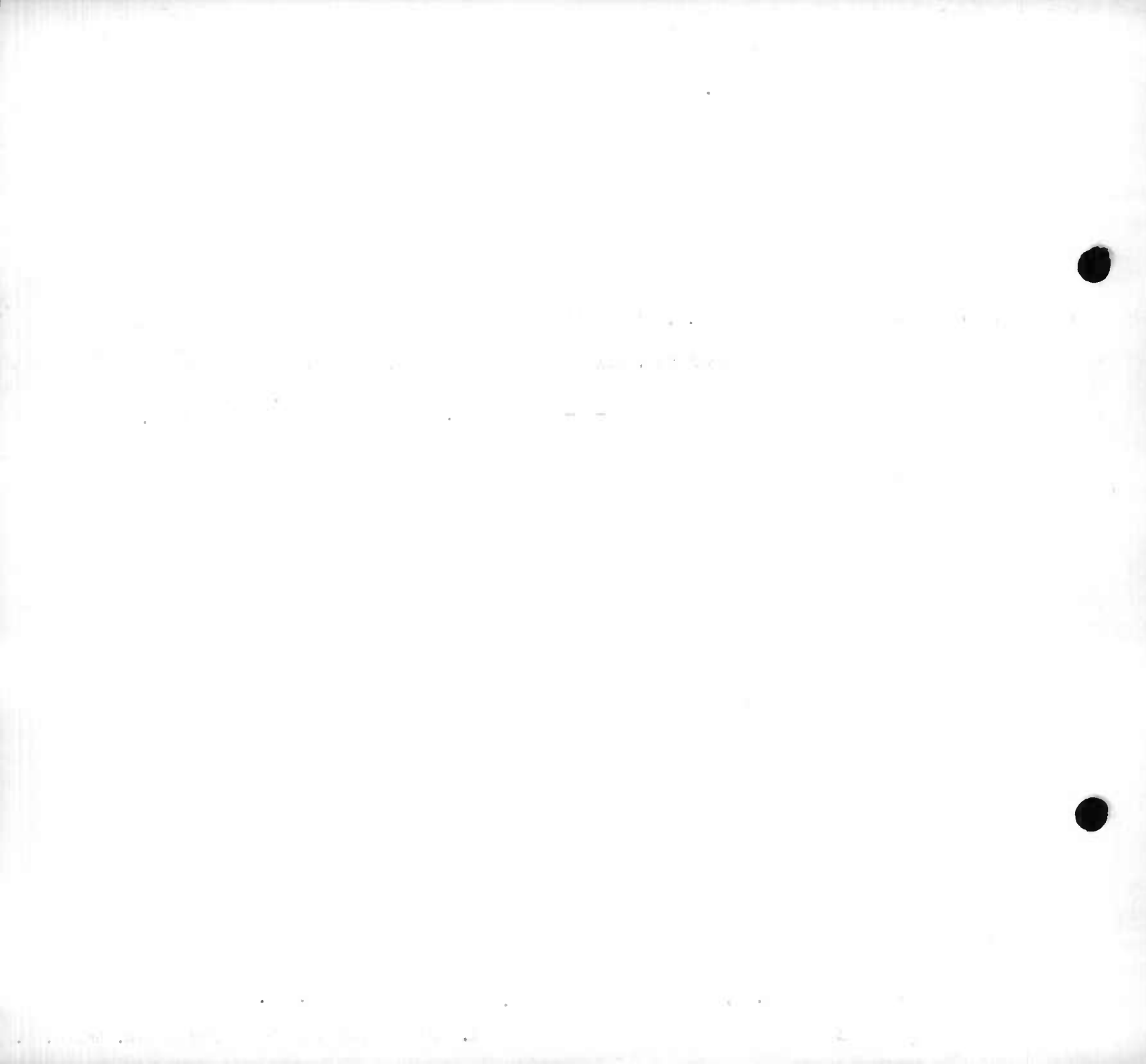
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Truman Schwab 3512 Frederick Ave. Balto. Md.

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00770	
BIRTH NO. 70 00770		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FIDELIS M <sup>rs</sup> Mary.		2. DATE AND HOUR OF DEATH 1/18/70 7 <sup>10</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home + Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co. 53-00 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1912 Robinwood Road 21222			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/91	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME George Samaras.		14. MOTHER'S MAIDEN NAME Unknown.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 236-142097		17. INFORMANT Daughter - Cleo Henis - 1912 Robinwood Road 21222	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1/10 to 1/18 1970 that (I) (we) last saw the deceased alive on 1/18 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Joe Martin 23B. DATE SIGNED 1/18/70 23C. PHYSICIAN'S NAME (Type) JOSE MARTINEZ MD 23D. ADDRESS Medical Arts Bldg. 21201 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-21-70 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970 25B. NAME OF REGISTRAR E. J. Taylor, Jr. 25C. FUNERAL DIRECTOR N. J. Matthews 25D. ADDRESS 10301 Eastern Ave. Baltimore, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>147641</u>
BIRTH NO. <u>70 00771</u>				
1. NAME OF DECEASED (Type or Print) <u>NORTH LOUISE J.</u>		2. DATE AND HOUR OF DEATH <u>1/19/70 at 6:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2741</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4716 SCHUEY AVE</u>		
5. SEX <u>F</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/11</u>	9. AGE (In years last birthday) <u>58y</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Herman S. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Nannie S. Spedden</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-7496</u>		17. INFORMANT <u>Mr. Herbert M. North</u>
				ADDRESS <u>Same</u>
18. <u>202.9</u> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>IDIOPATHIC THROMBOCYTOPENIC PURPURA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <u>SP HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF:				
(B) <u>? VASCULITIS</u> DUE TO, OR AS A CONSEQUENCE OF:				
(C) <u>? ALEUKEMIC LEUKEMIA</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/17/70</u> to <u>1/19/70</u> that (I) (we) last saw the deceased alive on <u>1/19/70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1/19/70</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. NEELAM KAPOR M.D.</u>		23D. ADDRESS <u>[Address]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/22/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Dorchester Memorial Park</u>	24D. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>	25B. NAME OF REGISTRAR <u>[Signature]</u>	25C. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>Edward J. Ruck Inc. 5305 Harford Road 21214</u>	

15700 05

15700 05

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>70 00772</u>				
BIRTH NO. <u>70 00772</u>					M.E. CASE NO. <u>Elizabeth</u>				
1. NAME OF DECEASED (Type or Print) <u>Mary E. Bennett</u>					2. DATE AND HOUR OF DEATH <u>11/20/70</u> <u>11:10 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> <u>5300</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> <u>Baltimore, Maryland</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore city</u>				
					D. STREET ADDRESS (If rural, give location) <u>2500 Ambler Court</u>				
5. SEX <u>Female</u>		6. RACE <u>Cauc.</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>2/14/35</u>		9. AGE (In years last birthday) <u>34</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Millard Marshall</u>					14. MOTHER'S MAIDEN NAME <u>Marie Yester</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-34-9664</u>		17. INFORMANT <u>Mr Gary C Bennett</u>		
					ADDRESS <u>Same</u>				
18. <u>013.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic lung disease</u>					CAUSE OF DEATH <u>Chronic lung disease</u>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>					(A) DUE TO <u>Chronic lung disease</u>				
					(B) DUE TO <u>Phosphorus 20 to 20H's disease</u>				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>Pneumonia</u>				
19A. DATE OF OPERATION <u>1/120/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Respiratory Arrest</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> <u>1970</u> to <u>1/20</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Stuart V. Grandie</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/20/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Stuart V. Grandie</u>					23D. ADDRESS M.D. <u>Maryland General Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/23/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 22 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Sabin M.D.</u>		25C. FUNERAL DIRECTOR <u>Donald W. Ruck Inc.</u>		ADDRESS <u>Baltimore, Maryland</u>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-420

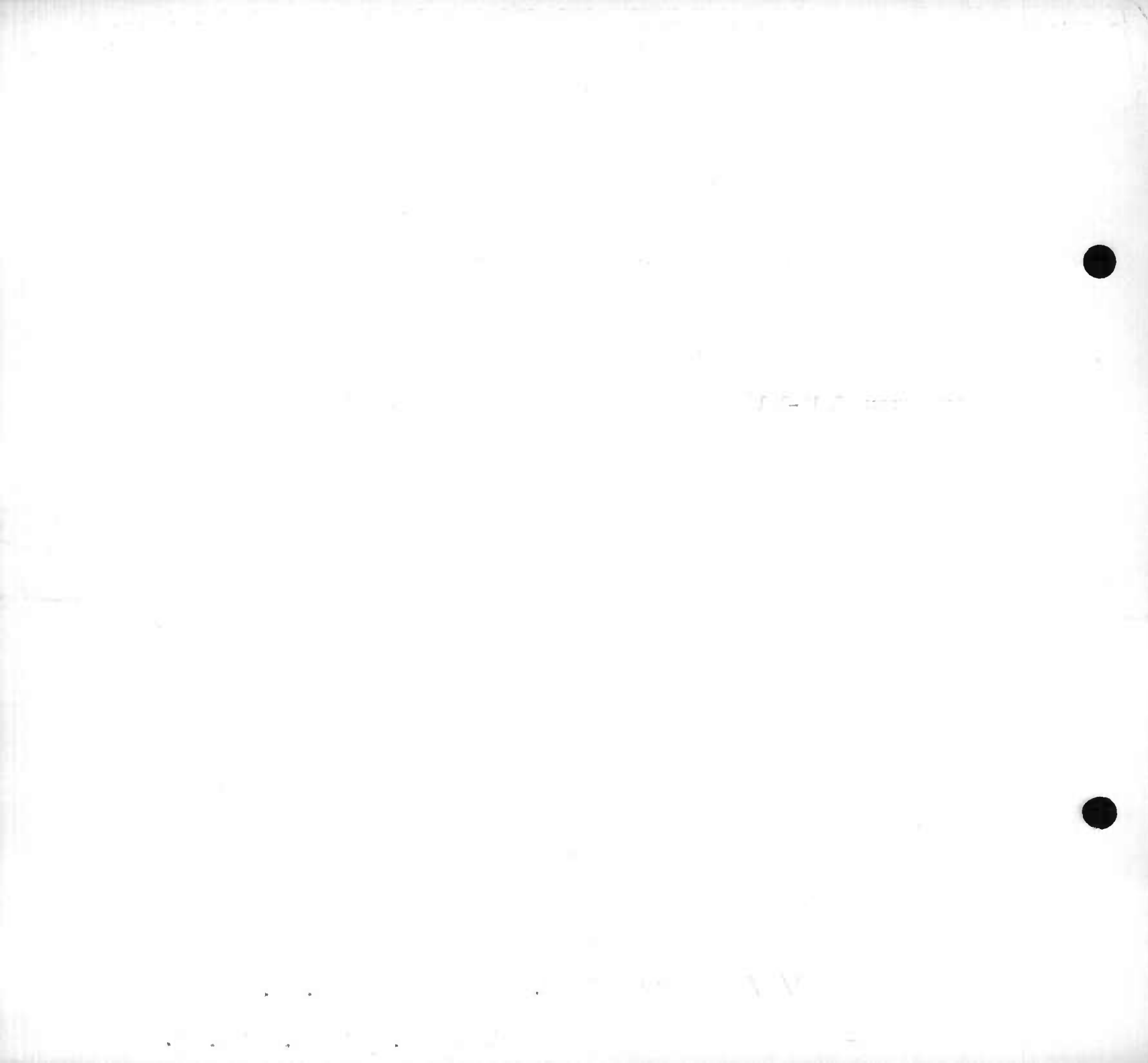
70 00773

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

70 00773

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM A. KLOCH</b>		2. DATE AND HOUR OF DEATH <b>JAN 21, 1970, 3<sup>00</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		5. AGE (in years last birthday) <b>76</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV OF MD HOSP.</b> <b>38</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2904 BAYONNE AVE</b>		6. SEX <b>M</b>		7. RACE <b>W</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>7/25/93</b>		10. AGE (in years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Kloch</b>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>1912-1916</b>		16. SOCIAL SECURITY NO. <b>213-09-2284</b>		17. INFORMANT <b>HOSP CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOCLAR NEPHROSCLEROSIS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>ADENOCARCINOMA PROSTATE</b>				<b>5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>DEC 22 1969</b> to <b>JAN 21 1970</b> that (H) (we) last saw the deceased alive on <b>JAN 22 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marvin J. Gordon, M.D.</b>		23B. DATE SIGNED <b>1/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>MARVIN J. GORDON, M.D.</b>	
23D. ADDRESS <b>DEPT. MEDICINE UNIV. OF MD HOSP</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Bal to., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, D.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Bal to., Md.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

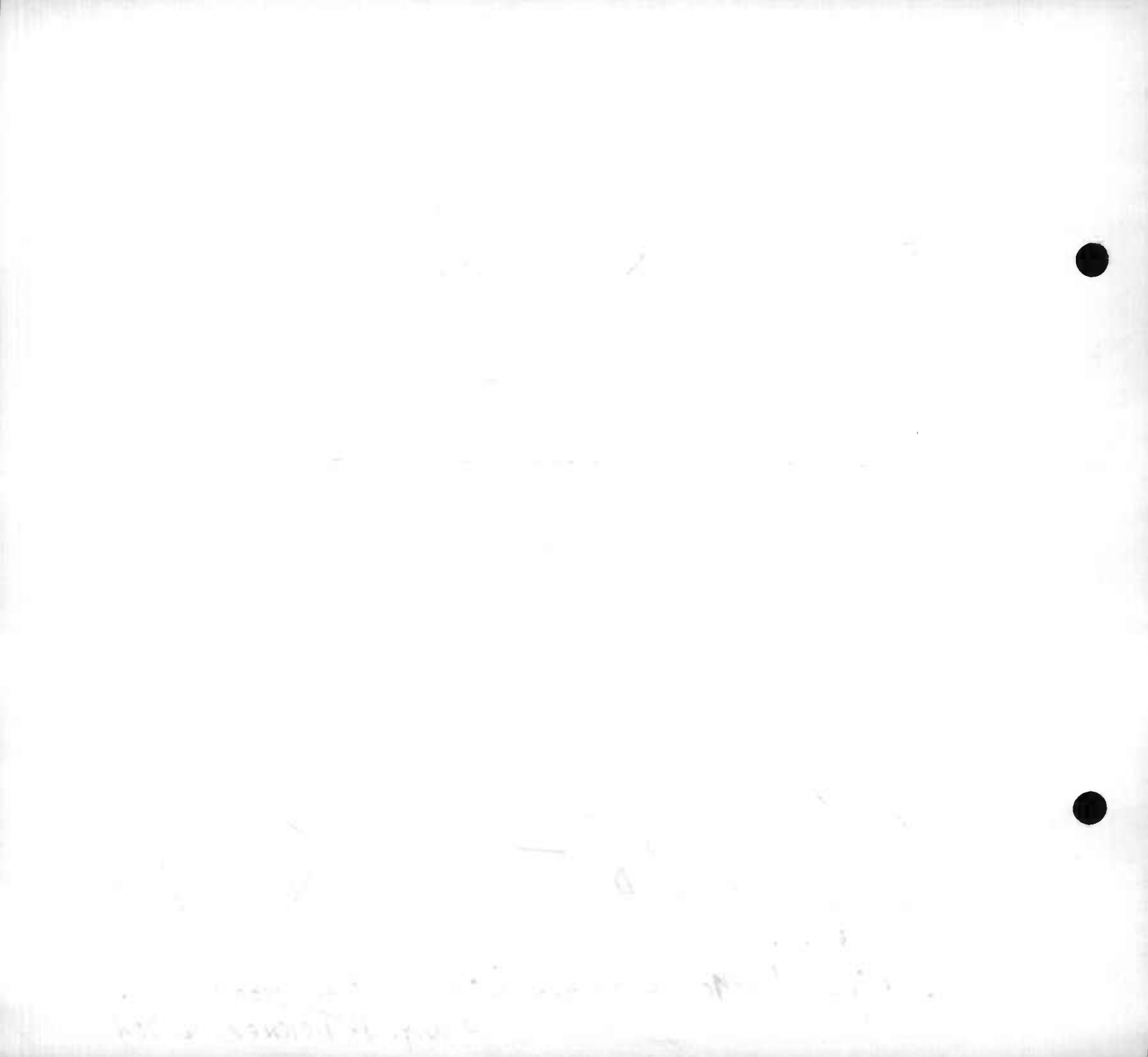
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00774	
BIRTH NO. 70 00774		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) SPAULDING GEORGE A		2. DATE AND HOUR OF DEATH 1/17/70 11 20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY 12 06	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1 W 21th ST	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74
			11. BIRTHPLACE (State or foreign country) BALTO. MD.
13. FATHER'S NAME CHARLES E. SPAULDING		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME ALICE C. BROWNING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I NAVY		16. SOCIAL SECURITY NO. 212054705	
17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral edema	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
MEDICAL CERTIFICATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/17 1970 to 1/17 1970 that (I) (we) last saw the deceased alive on 1/17 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Anne L. Leddy M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS Union Memorial Hospital Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-70	
24C. NAME of CEMETERY or CREMATORY MT. OLIVET		24D. LOCATION (City, town, or county) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR Robert E. Sabat, M.D.	
25C. FUNERAL DIRECTOR Wm J. Tickner & Sons		ADDRESS NEPA AVES.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00775	
BIRTH NO. 70 00775				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELIZABETH BLACKISTON ARCHER			2. DATE AND HOUR OF DEATH JAN 21, 1970 11 <sup>15</sup> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY MARYLAND Hospital 38			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 301 McMechen ST. Apt 208		
5. SEX F	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/97	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JAMES THOMAS BLACKISTON		
14. MOTHER'S MAIDEN NAME FLORENCE KEYSER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. 553.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) SHOCK DUE TO, OR AS A CONSEQUENCE OF: (C) Post-operative hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours 5 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION JAN. 16/1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HIATUS hernia - cholelithiasis		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JAN 9 1970 to JAN 21 1970 that (X) (we) last saw the deceased alive on JAN 21 1970 and that (in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. M. Blackhead M.D.			23B. DATE SIGNED Jan. 21		23C. PHYSICIAN'S NAME (Type) J. M. Blackhead M. D.
23D. ADDRESS University Hospital			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 1/24/70			24C. NAME OF CEMETERY OR CREMATORY WOODLAWN Cem.		
24D. LOCATION BALTIMORE, MD.			25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		
25B. NAME OF REGISTRAR Robert A. Taylor M.D.			25C. FUNERAL DIRECTOR Wm. J. Tickner & Son		



H-520

1

BALTIMORE CITY HEALTH DEPARTMENT

X

70 00776

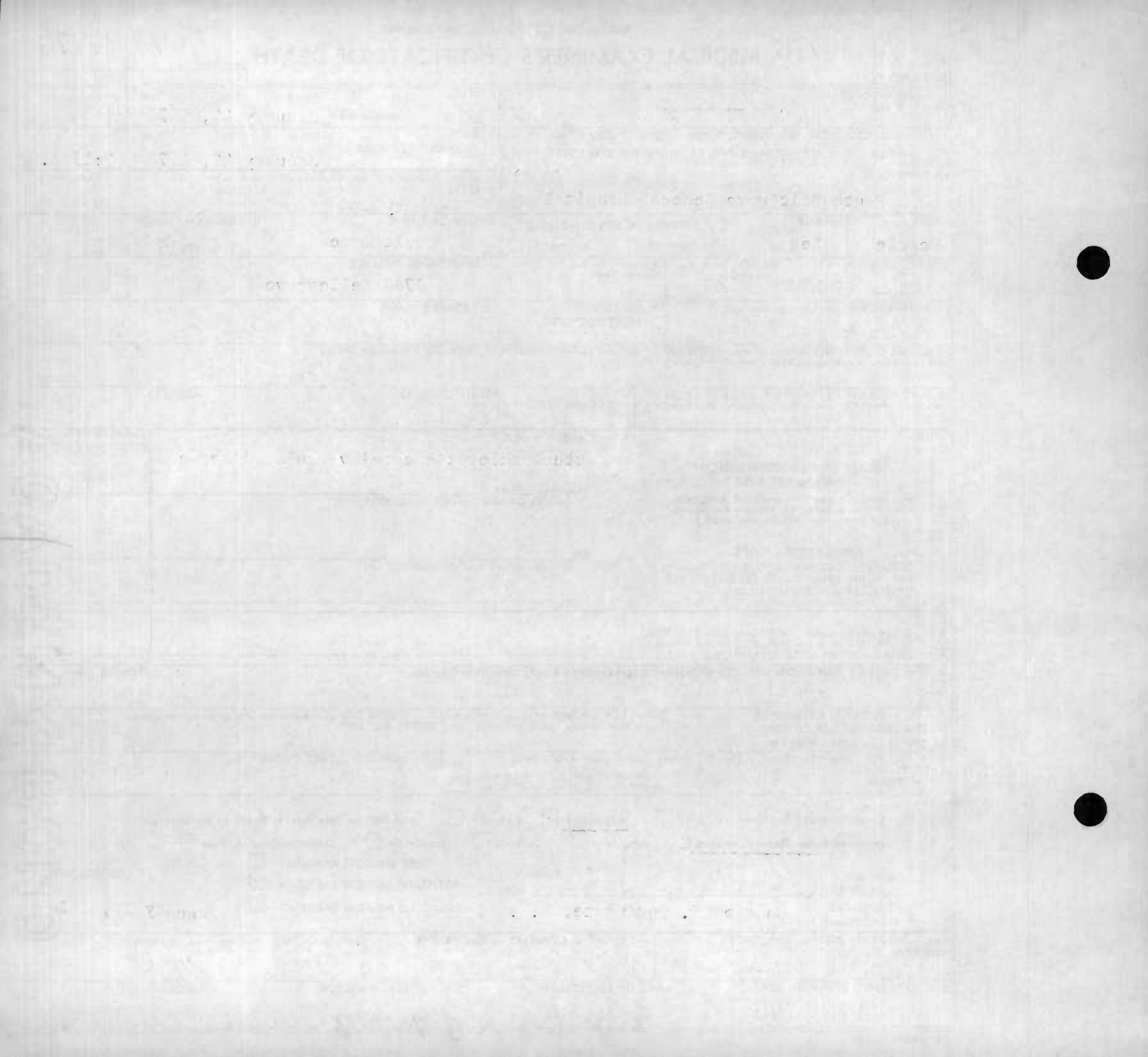
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00776

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CARRIE HINES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 22, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 22, 1970</b>		Hour <b>2:15 A.M.</b>
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>June 14-1903</b>		10. AGE (In years last birthday) <b>66</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>5743 Bellegrove Road</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>John Brooks</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>George Hines Same</b>
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> DATE SIGNED <b>January 22, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Northwood</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Zuber, M.D.</b>		25C. FUNERAL DIRECTOR <b>George Allison</b>		
25D. ADDRESS		25E. ADDRESS		



D-200

1

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JENNIE DIGGS

2. DATE  
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 20, 1970

1:30 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1802

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov. 27, 1919

10. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1202 W. Fayette Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Johnson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Factory Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ethel Hughes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Catherine Eulanks 1735 E. 30th St.

ADDRESS

19. 480 X I

CAUSE OF DEATH

Lobar Pneumonia

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If In Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/26/1970

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balt. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

Robert E. Jaber, M.D.

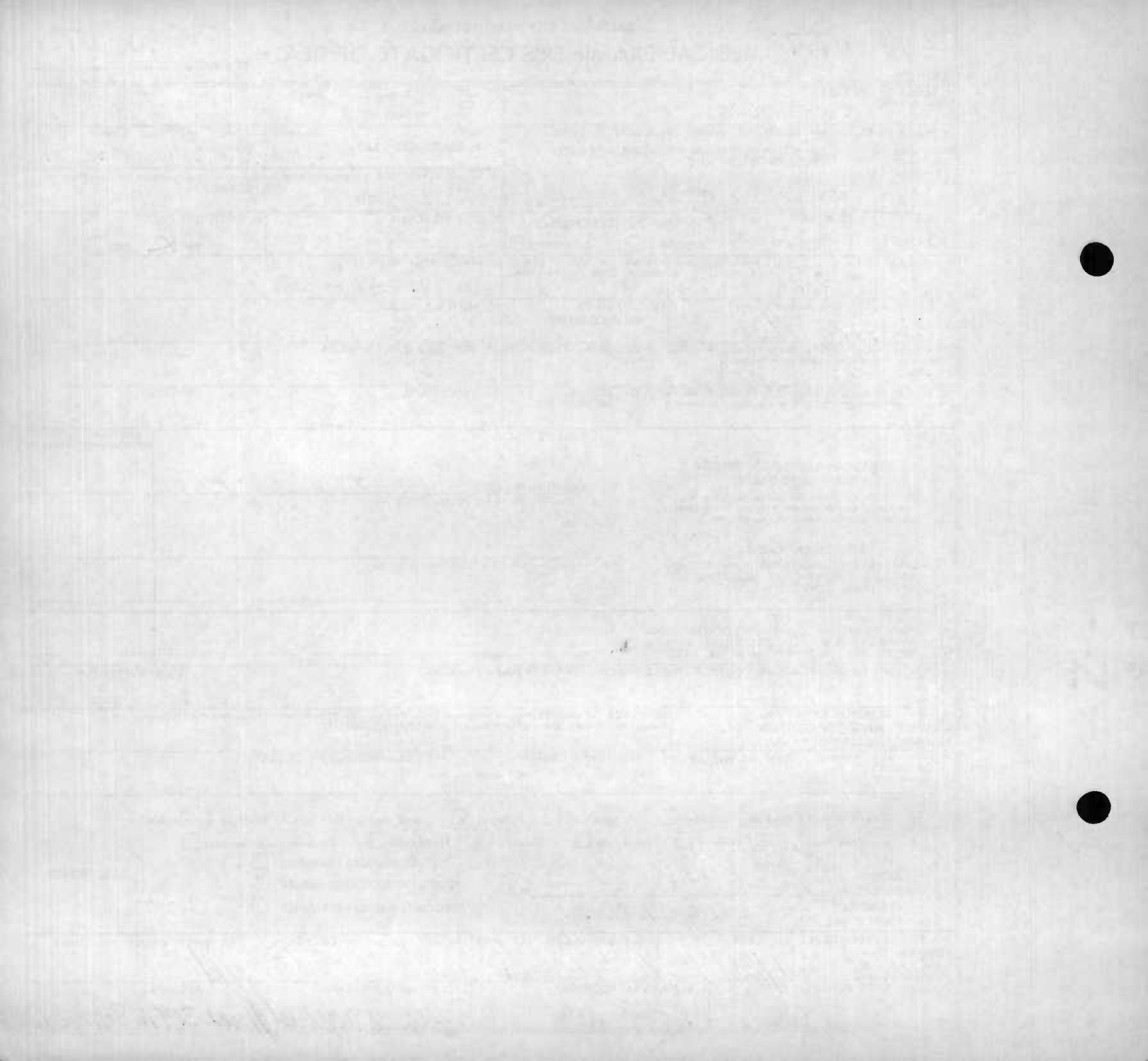
25C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

319 N. Schroeder St.







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260

70 00778

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 00778

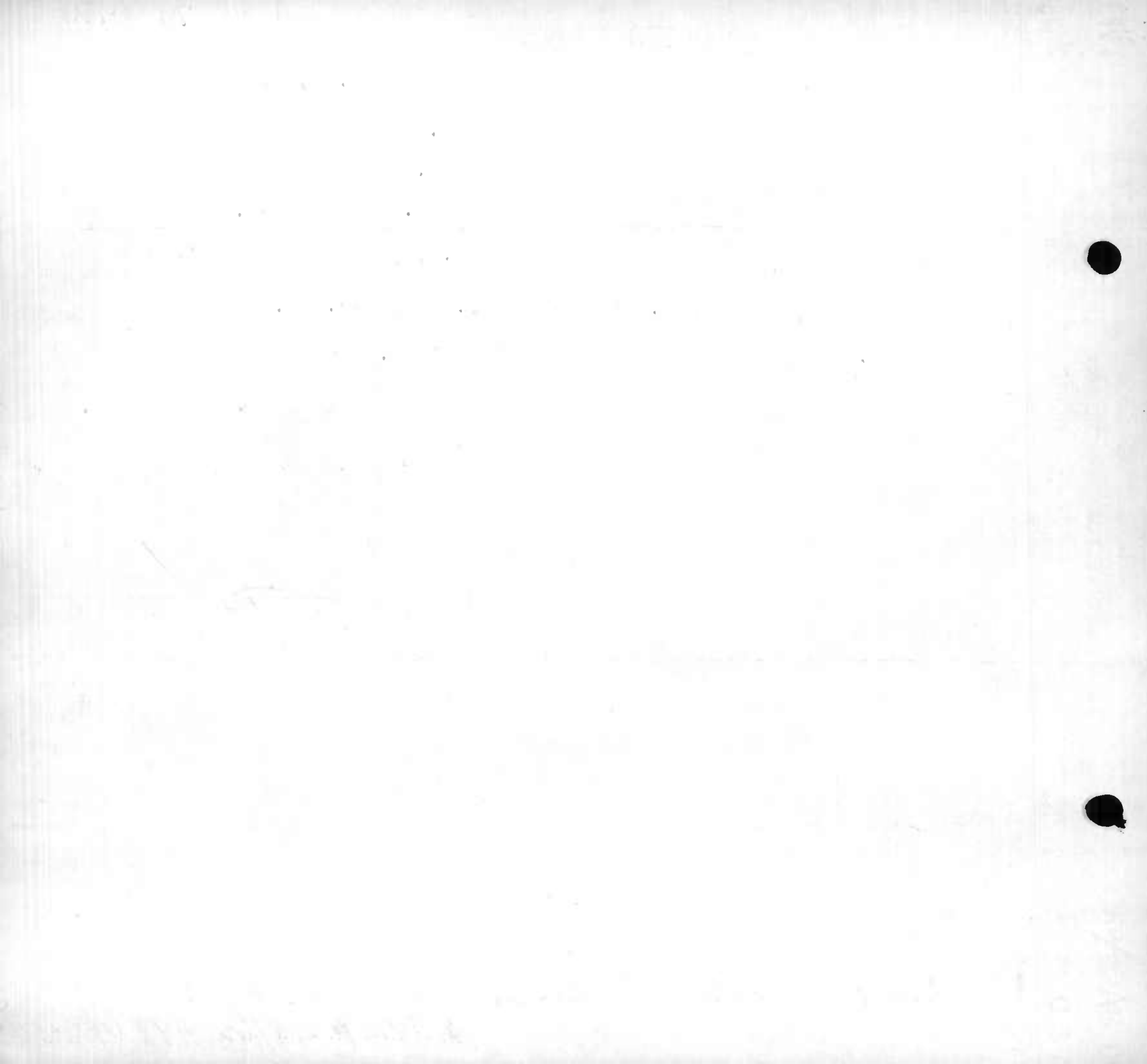
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BOWSER, WILLIAM</b>		2. DATE AND HOUR OF DEATH <b>1-20-70 4<sup>45</sup> am M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOUR HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Packer</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>9-04-05</b> 9. AGE (in years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>GLOVER BOWSER</b>		14. MOTHER'S MAIDEN NAME <b>MARY HENSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>A218-10-0808</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> ADDRESS	
18. <b>582X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Renal Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Renal Failure</b> <b>2</b> <b>Uremia</b> (B) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 10 days</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/9/70</b> to <b>1/20/70</b> that (I) (we) last saw the deceased alive on <b>1/19/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vongvattanyu</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>V. VONGVATTANYU</b>	
23D. ADDRESS <b>Bon Secours Hospital</b>		23E. DEGREE <b>MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/24/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arcturus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR <b>William's Funeral Home</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>		25C. ADDRESS <b>314 N. Schroeder St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00779	
BIRTH NO. 70 00779		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN CARL HOLLY</b>			2. DATE AND HOUR OF DEATH <b>JAN. 20, 1970</b> <b>4 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1901</b>		
5. SEX <b>Male</b>			6. RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Apr. 3, 1907</b>		9. AGE (In years last birthday) <b>62</b>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Apt. House</b>		11. BIRTHPLACE (State or foreign country) <b>St. Marys Co. Md.</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>John A. Holly</b>		
14. MOTHER'S MAIDEN NAME <b>Mable L. Curtis</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mildred Holly 101 N. Fulton Ave.</b>		
18. <b>485 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Broncho Pneumonia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15</b> to <b>Jan 20</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>Jan. 20</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Morris B. Schreier M.D.</b>				23B. DATE SIGNED <b>1-22-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>MORRIS B. SCHREIER M.D.</b>				23D. ADDRESS <b>1519 W. Lombard St. Baltimore Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Adolphus Cems.</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		24F. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	



1  
R-200

70 00780

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00780

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JAMES RICE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 14, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 918 W. Franklin Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 14, 1970 11:30 P.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1601	
7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH April 1928	10. AGE (In years last birthday) 41	E. STREET AND NUMBER 918 W. Franklin Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		13. FATHER'S NAME George W. Rice	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Jessie Watkins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Family		ADDRESS 614 N. Arlington Ave	
19. 4-28-70		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Focal interstitial myocardial fibrosis DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2-28-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 15, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1970		25B. NAME OF REGISTRAR Robert E. Vahey, M.D.	
25C. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington Ave		1011-13 ADDRESS	

Letter from M.E.'s office

2-11-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00781		70 00781	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ADDIE Z. ANDERSON. (ANDERSON)				1-20-70.		3:23 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
				MD.		1-03	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
BALTO.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				618, S. MILTON AVE. #21224			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-21-05	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
64		HOUSE WORK		S. CAROLINA		U.S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DARLEY JACKSON				ADELINE ARD.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				218-07-0597		WILLIAM F. ANDERSON HUSBAND. <del>MR. ANDERSON</del> SAME	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		6 MTHS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) COLONIC CA. DUE TO, OR AS A CONSEQUENCE OF:		1 YR.	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ESSENTIAL HYPERTENSION		10 YRS.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (H) (this hospital) attended the deceased from 12-18-69 to 1-20-70 that (H) (we) last saw the deceased alive on 1-20-70 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J.H. MATHER				1-20-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J.H. MATHER				MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1-23-70		OAK LAWN CEM.		7225 EASTERN BLVD. BA. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 23 1970		Robert E. Jolley, M.D.		Charles D. Zeiler		901 S. CORREING ST. BALTO., 21224, MD.	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN H. ENNALS

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 14, 1970

6:55 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1912

10. AGE (In years  
lost birthday) 57If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2228 Callow Avenue

11. BIRTHPLACE (State or foreign country)

Dorchester County, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Otis Green

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Laborer

15. MOTHER'S MAIDEN NAME

Berthana Ennals

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-07-8071

18. INFORMANT

Berthana Whitner, Baltimore, Md.

ADDRESS

19. 533.9 I

CAUSE OF DEATH

Gastrointestinal Hemorrhage

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Bleeding peptic ulcer

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty Metamorphosis of Liver

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes (Partial)

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ (Partial)  
Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/19/1970

24C. NAME OF CEMETERY or CREMATORY

Old Field Cemetery

24D. LOCATION

(City, town, or county)

(State)

Dorchester County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Frederick G. Delair

ADDRESS

ST. CLAIR F. HOM E  
Cambridge, Md.

ACADEMY OF MUSIC

McLendon

WALTER H. HARRIS

2076

11

Walter H. Harris

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 00783		70 00783		70 00783	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Jean Muir		Jan 21, 1970 10:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
90 Edgewood Nursing Home		Md		BALTO. CO.	
6000 Bellona Ave		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Beltz		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		8803 Avondale Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 10, 1874	96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Spartland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Muir		Mary Todd		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		217-31-3330		Mrs Mary Canning 8803 Avondale Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Cerebral vascular insufficiency 12yr			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic cardiovascular disease 2+yr			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 1968 to _____ 1970, that (I) (we) last saw the deceased alive on _____ 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Frederick J. Vollmer MD		Jan 22, 1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FREDERICK J. VOLLMER MD		6100 YORK RD BALTO. MD 21212			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/24/70		S.S. Peter & Paul, Cumberland Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 23 1970		R. E. Fahey, R.D.		Frederick J. Vollmer	
				ADDRESS	
				7200 Highland Rd	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00784	
BIRTH NO. 70 00784		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>Vanik, Margaret P</i>		2. DATE AND HOUR OF DEATH <i>1-18-70 9:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>PERRY HALL</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>4209 SILVER SPRINGS RD</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-24-26</i>	9. AGE (In years last birthday) <i>43 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>American Bureau of Shipping</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>WILLIAM CRAWFORD</i>		14. MOTHER'S MAIDEN NAME <i>CORA BRANDERBURG</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-20-9623</i>		17. INFORMANT <i>James E. Vanik - 4209 Silver Spring Rd.</i>	
18. <i>183.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Ovarian Cancer</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(1)</i> <i>(this hospital)</i> attended the deceased from <i>12/27/69</i> to <i>1/18/70</i> , that <i>(I)</i> <i>(we)</i> last saw the deceased alive on <i>1/17/70</i> and that in <i>(my)</i> <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(we)</i> <i>(did)</i> <i>(not)</i> view the body after death.					
23A. SIGNATURE <i>W. B. Waddill Jr.</i>		23B. DATE SIGNED <i>1/18/70</i>		23C. PHYSICIAN'S NAME (Type) <i>W. B. WADDILL, JR., M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-21-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR <i>John T. Miller Inc 6415 Belair Rd. - 21206</i>			

Overland

No

No

11/18/10 11/18/10 11/18/10

11/18/10  
of 11/18/10

11/18/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620-1		70 00785		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 00785	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		ROSEMARY DOROSZ		1-20-70 10 30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
				MARYLAND		BALTIMORE	
37 MERCY HOSP				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				411 MAGNOLIA RD.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year	11. Under 24 Hrs.	
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-13-54	15	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHILD				MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LAWRENCE DOROSZ				EDITH KESSLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		NONE		Lawrence Dorosz 411 Magnolia Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
204.9 I CARDIO-RESPIRATORY							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) IMMEDIATE CAUSE							
DUE TO, OR AS A CONSEQUENCE OF:							
RECURRENT Lymphocytic							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
LEUKAEMIA							
(C) _____							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (N) (this hospital) attended the deceased from JAN. 20th 1970 to JAN 30th 1970 that (H) (we) lost saw the deceased alive on 1/20 1970 and that (Int) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Patrick A. Molony MD				1/20/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Patrick A. Molony				5377 Carriage Court			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/24/70		Holy Cross Cemetery		Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 23 1970		Robert E. Bailey, R.D.		Raymond C. Fink		Glen Burnie, Md.	

RESEARCH LABORATORY  
HARVARD

RESEARCH LABORATORY  
HARVARD

NO

RESEARCH LABORATORY  
HARVARD

RESEARCH LABORATORY  
HARVARD



B-625 1

70 00786

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 00786

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARNOST BURGEMEISTER

2. DATE AND HOUR OF DEATH

Jan. 20, 1970

8:45

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)US Public Health Service Hospital  
3100 Wyman Parkway4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Florida

C. CITY OR TOWN

Miami

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1701 SW 17th Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11/18/19

9. AGE (In years  
last birthday)

55

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

France Burgemesiter

14. MOTHER'S MAIDEN NAME

Francisca Vachova

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL

SECURITY NO.

340-28-2979

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

151.9

I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Peritonitis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Carcinoma of stomach

Months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 15 19 69 to Jan. 20 19 70,  
that (I) (we) last saw the deceased alive on Jan. 20 19 70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter J. Philpott MD

DEGREE

Attending ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/20/70

23C. PHYSICIAN'S  
NAME (Type)

Peter J. Philpott, Surgeon (R)

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-26-1970

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Park

24D. LOCATION

(City, town, or county)

(State)

Miami, Florida

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

Jm. Cook-Brooks

25C. FUNERAL DIRECTOR

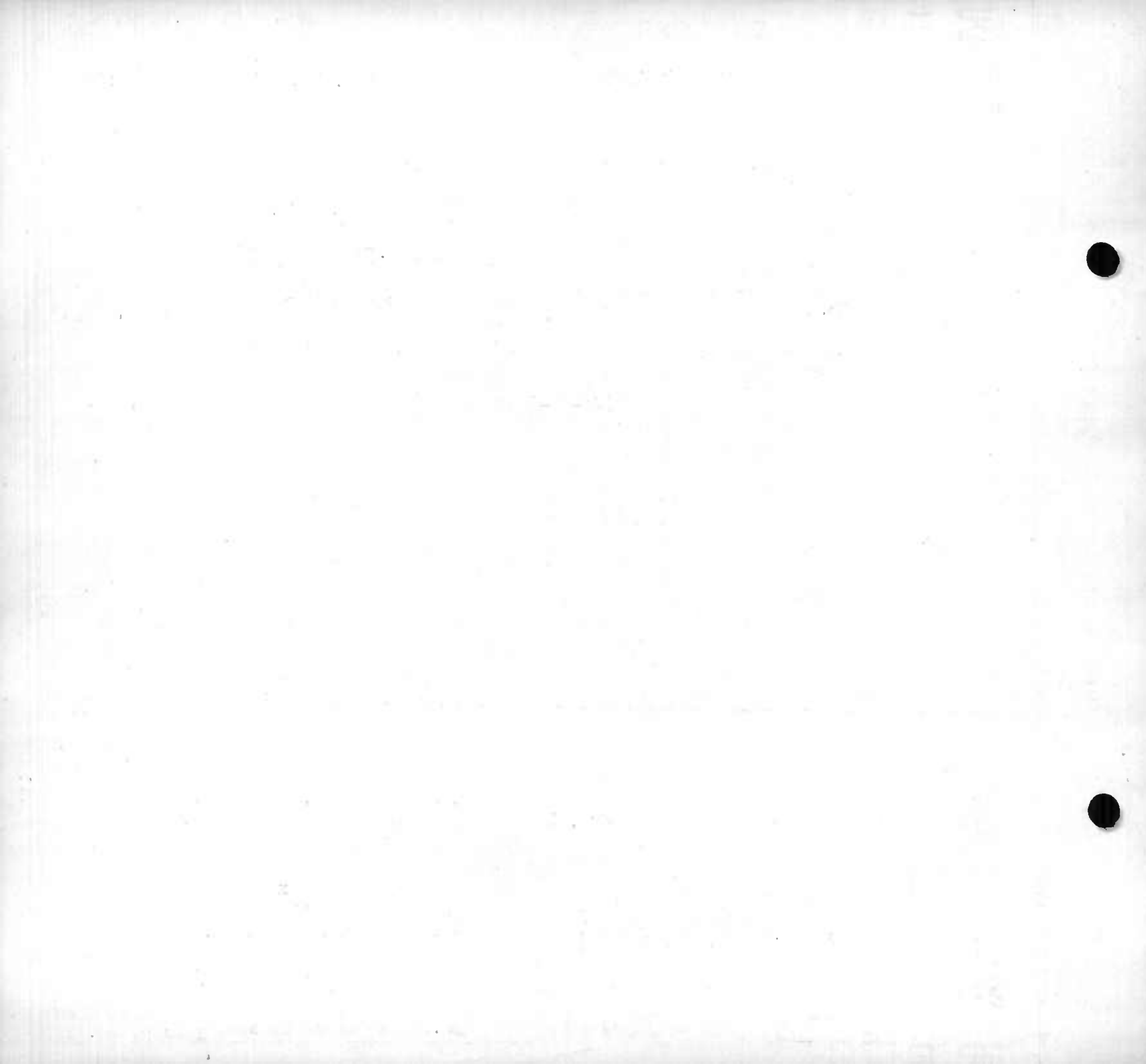
1050 York Road  
Towson, Md. 21204

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00787

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

70 00787

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLAYTON, CHARLES R.		JANUARY, 21st 1970 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 916 MONTEPELIER STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-07-11	9. AGE (In years lost birthday) 38
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM CLAYTON				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				14. MOTHER'S MAIDEN NAME FANNY	
16. SOCIAL SECURITY NO. 220-09-2477				17. INFORMANT IRENE CLAYTON	
				ADDRESS same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 514X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bilateral pulmonary edema and pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: M.M. (C)	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 18 1970 to JANUARY 21 1970 that (I) (we) last saw the deceased alive on JANUARY 21 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Cabrera				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JUAN CABRERA				23D. ADDRESS UNION MEMORIAL HOSPITAL.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-1970		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR E. J. Taylor, D.O.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks	
				ADDRESS Towson, Md. 21204	

MEMORIAL SERVICE

MALE WHITE

PRINTED

WILLIAM CLAYTON

FAMILY

IRVING CLAYTON

COL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

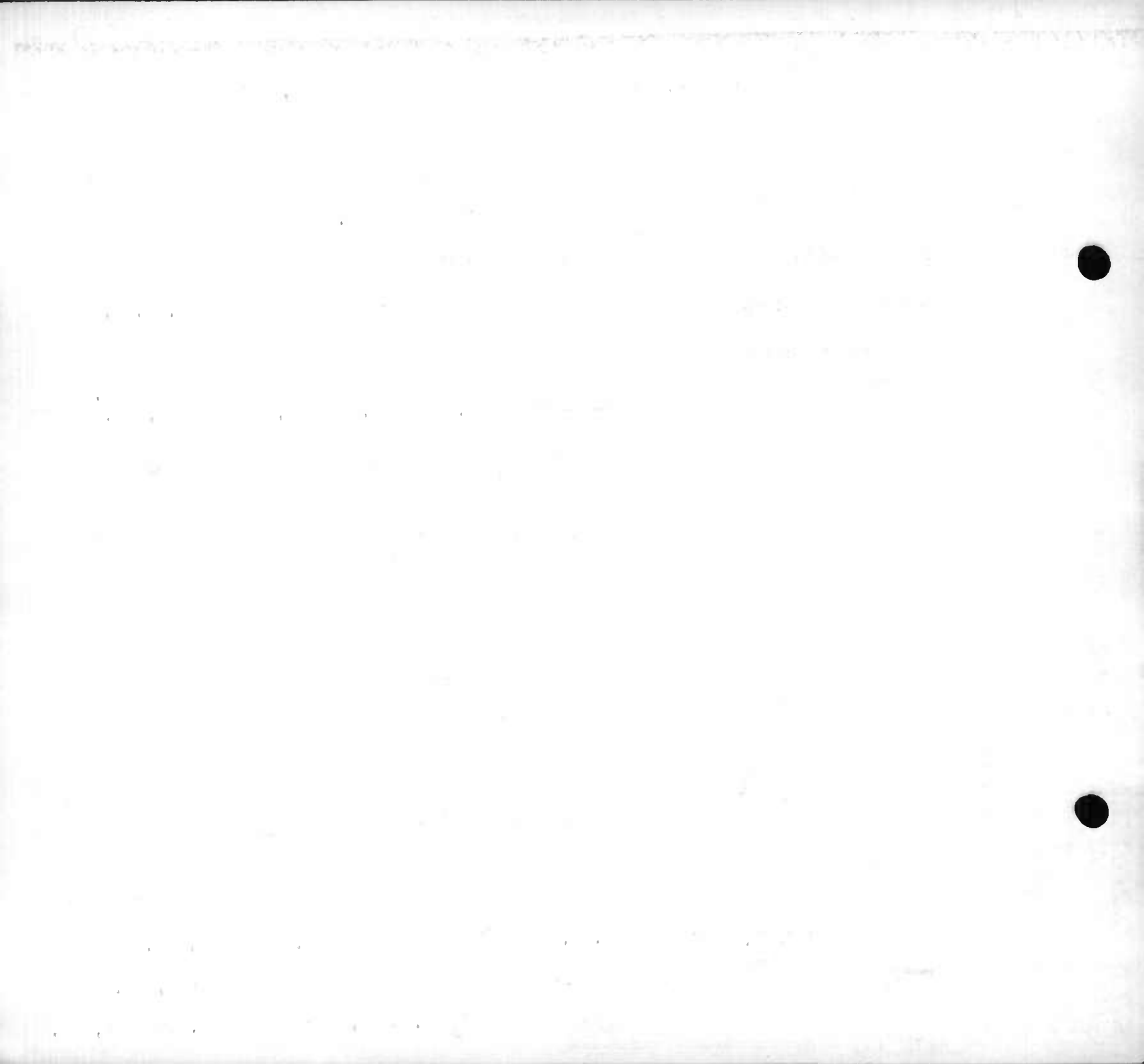
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 00788</b>	
70 00788				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Charles E Kenner</b>			2. DATE AND HOUR OF DEATH <b>Jan 21, 1970</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>2544</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>841 Pontiac Ave Baltimore, Md</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>841 Pontiac Ave</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/05</b>	9. AGE (in years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Harbison-Walker</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Leroy Kenner</b>			14. MOTHER'S MAIDEN NAME <b>Ida Folk</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Martha E Kenner 841 Pontiac Ave 21225</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.9 I</b> <b>coronary occlusion</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>hypertensive CV disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>diabetes mellitus</b> (C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1954</b> to <b>Jan 1970</b> , that (I) (we) lost saw the deceased alive on <b>1.7.1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip R. Keister</b>			23B. DATE SIGNED <b>1/21/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>P.W. KEISTER M.D.</b>			23D. ADDRESS <b>302 Patapsco Ave Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/24/70</b>	24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Mem Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Reg E. J. B. J. R. D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully &amp; Co 37 Patapsco Ave 21225</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 00789	
BIRTH NO. 70 00789		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Melvin J. McFaul</b>		2. DATE AND HOUR OF DEATH <b>January 21, 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> <b>53-00</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician &amp; Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>1/7/09</b>	
13. FATHER'S NAME <b>Martin McFaul</b>		14. MOTHER'S MAIDEN NAME <b>Anna Emberly</b>		9. AGE (In years lost birthdays) <b>61</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-6805</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
17. INFORMANT (Wife) <b>Mrs. Helen E. McFaul,</b>		ADDRESS <b>711 Wise Ave. Dundalk, Md. 21222</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>470 X 14250.9</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus</b>		CAUSE OF DEATH <b>Murderal Thelure</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Suicide</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>4 days</b> <b>1 yr</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1 - 1969</b> to <b>Jan 21 1969</b> that (I) (we) last saw the deceased alive on <b>Jan 20 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M B Davis</b>		23B. DATE SIGNED <b>1/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis M. D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25D. ADDRESS <b>6800 Mornington Rd. Dundalk, Md.</b>			

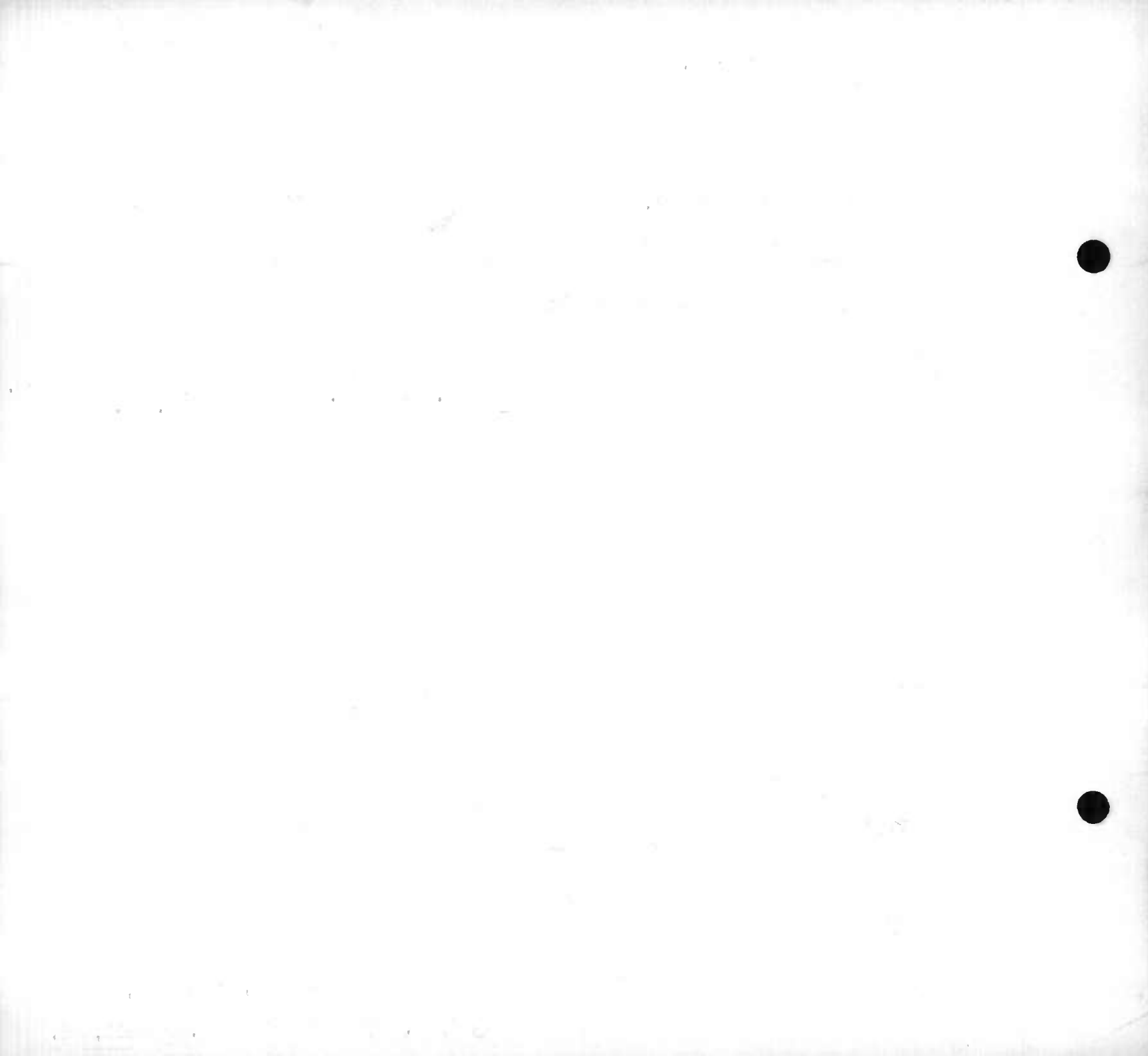




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

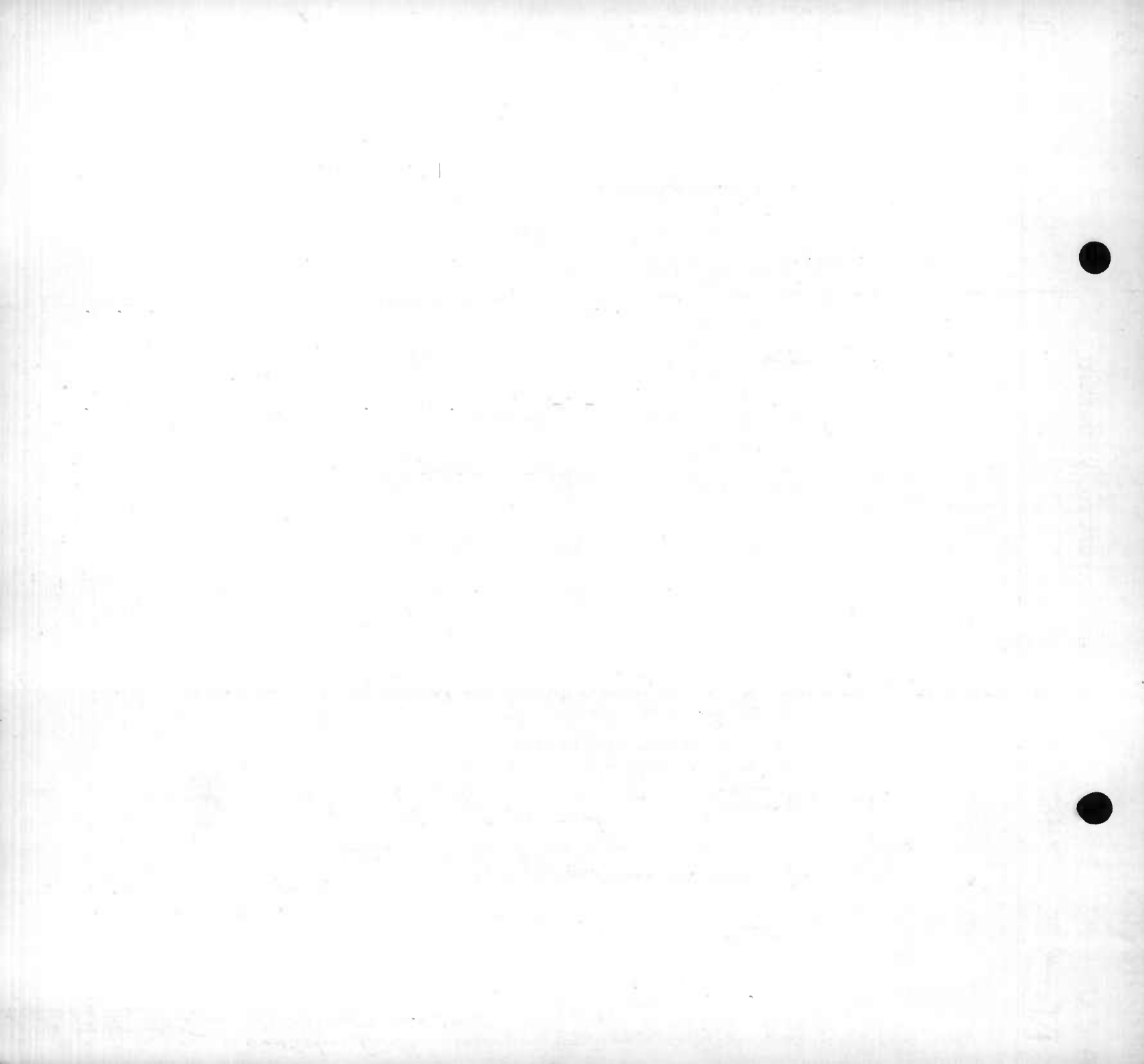
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>547</u>
BIRTH NO. <u>70 00790</u>		<b>CERTIFICATE OF DEATH</b>		<u>70 00790</u>
1. NAME OF DECEASED (Type or Print) <u>Luther F. Johnson</u>		2. DATE AND HOUR OF DEATH <u>1-21-70</u> <u>11:30</u> a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>HARBOR VIEW N.C.C.</u> <u>Harbor View Nursing &amp; Convl. Center</u>		A. STATE <u>MD.</u> B. COUNTY <u>Balti.</u> <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Edgemere</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER <u>7732 South Cove Road</u>		
		F. CITY OR TOWN <u>Edgemere</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-90</u>	9. AGE (In years last birthday) <u>79</u>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Holland Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>
13. FATHER'S NAME <u>JACOB JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ??</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-058914A</u>		17. INFORMANT <u>Wife:</u> <u>Mrs. Marion E. Johnson</u> <u>7732 South Cove Rd. Balto. Md. 21219</u>
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Broncho pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(B) Cerebral thrombosis</u> <u>(C)</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <del>(he)</del> <u>(she)</u> <u>(this hospital)</u> attended the deceased from <u>1-14</u> 19 <u>70</u> to <u>1-21</u> 19 <u>70</u> that <del>(he)</del> <u>(we)</u> last saw the deceased alive on <u>1-21</u> 19 <u>70</u> and that <del>(my)</del> <u>(our)</u> apintan death occurred on the date and hour and from the causes stated above. <del>(I)</del> <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.				
23A. SIGNATURE <u>H. C. Alevizatos, M.D.</u>		23B. DATE SIGNED <u>Jan 21, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>H. C. ALEVIZATOS, M.D.</u>		23D. ADDRESS <u>1209 St Paul St. Balto 21202</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/24/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park</u>	24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>	25B. NAME OF REGISTRAR <u>John J. Duda</u>	25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

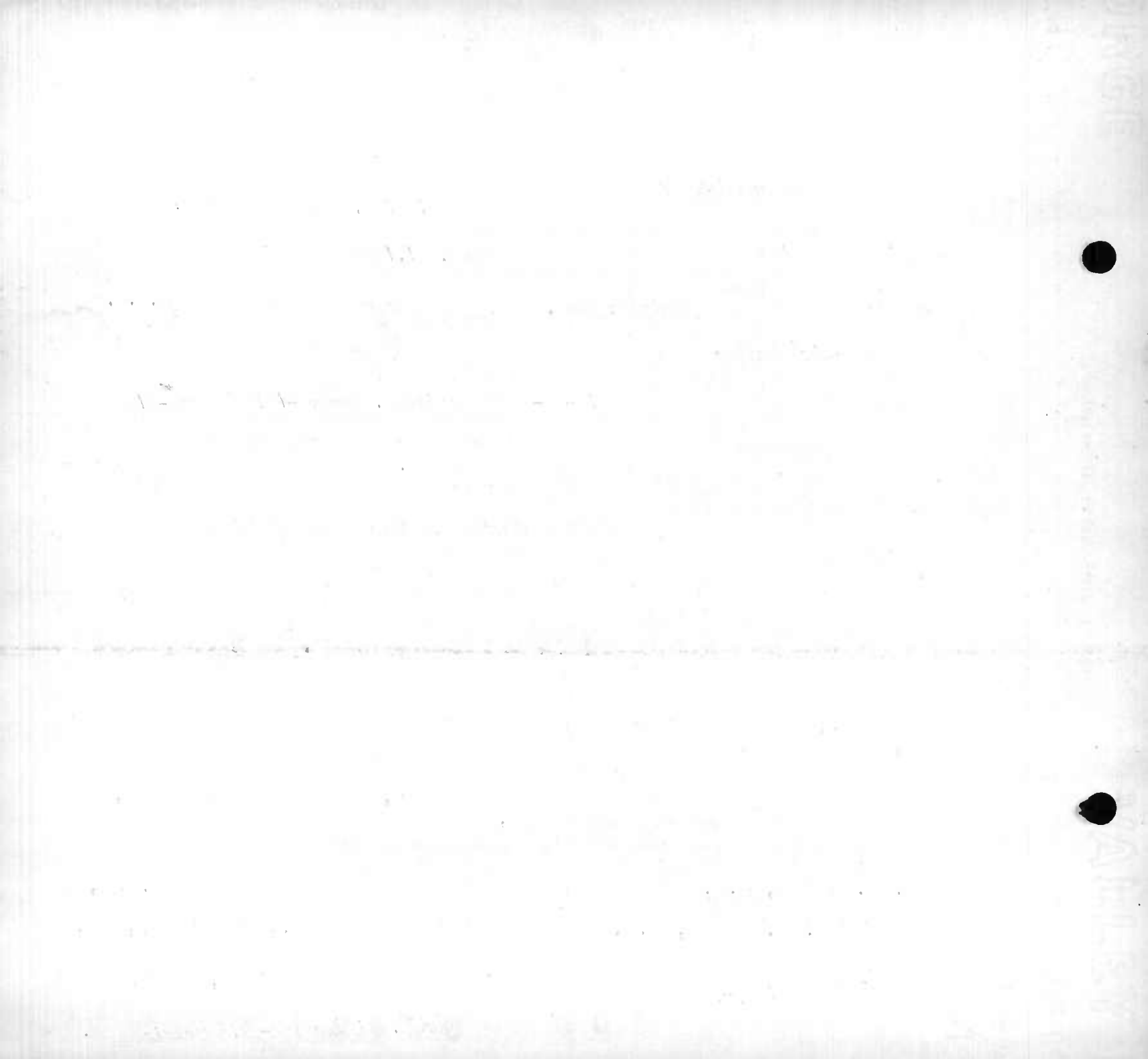
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00791	
BIRTH NO. 70 00791		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GERTRUDE SCOTT		2. DATE AND HOUR OF DEATH 01/18/70 7AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Montgomery Co 65-00 C. CITY OR TOWN SILVER SPRING D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1300 MORNINGSIDE DRIVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/17	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME BERT DODGE		14. MOTHER'S MAIDEN NAME MINNIE MOREY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 474-03-2881		17. INFORMANT ADDRESS 1300 Morningside Dr. Mr. Dale H. Scott Silver Spring, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  I 174X CAUSE OF DEATH Metastatic Breast Cancer 10 yrs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Liver failure					
19A. DATE OF OPERATION 2 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 9 1970 to Jan 18 1970, that (I) (we) last saw the deceased alive on Jan 18 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Hassmann MD		23B. DATE SIGNED 1/18/70		23C. PHYSICIAN'S NAME (Type) Gary Charles Hassmann MD	
23D. ADDRESS 601 North Broadway JHH					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Jan. 22, 1970	24C. NAME OF CEMETERY or CREMATORY Garden of Faith	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970	25B. NAME OF REGISTRAR J. E. Fisher, M.D.	25C. FUNERAL DIRECTOR O. Paul Smith - Wm. E. Murphy Silver Spring, Md. JH-9-5000			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00792	
BIRTH NO. 70 00792		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Eleanor Ewing</i>		2. DATE AND HOUR OF DEATH <i>January 20, 1970</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Edgewood Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2748</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1101 E. Belvedere Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 21, 1889</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hutzler Bros.</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Frederick Kuffer</i>		14. MOTHER'S MAIDEN NAME <i>Ober</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-22-8776</i>		17. INFORMANT <i>Louise O. Booze - 1810 Kenway - 21209</i>	
18. <i>188X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Metastatic carcinoma of brain.</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Carcinoma of the urinary bladder</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 18, 1970</i> to <i>January 20, 1970</i> , that (I) (we) last saw the deceased alive on <i>January 19, 1970</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. B. Velez, M.D.</i>		23B. DATE SIGNED <i>Jan. 21, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>B. B. Velez, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-23-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		24F. NAME OF REGISTRAR <i>John C. Miller Inc - 6415 Belair Rd.</i>	
24G. FUNERAL DIRECTOR <i>John C. Miller Inc - 6415 Belair Rd.</i>		24H. ADDRESS		24I. ADDRESS	



70 00793

BALTIMORE CITY HEALTH DEPARTMENT

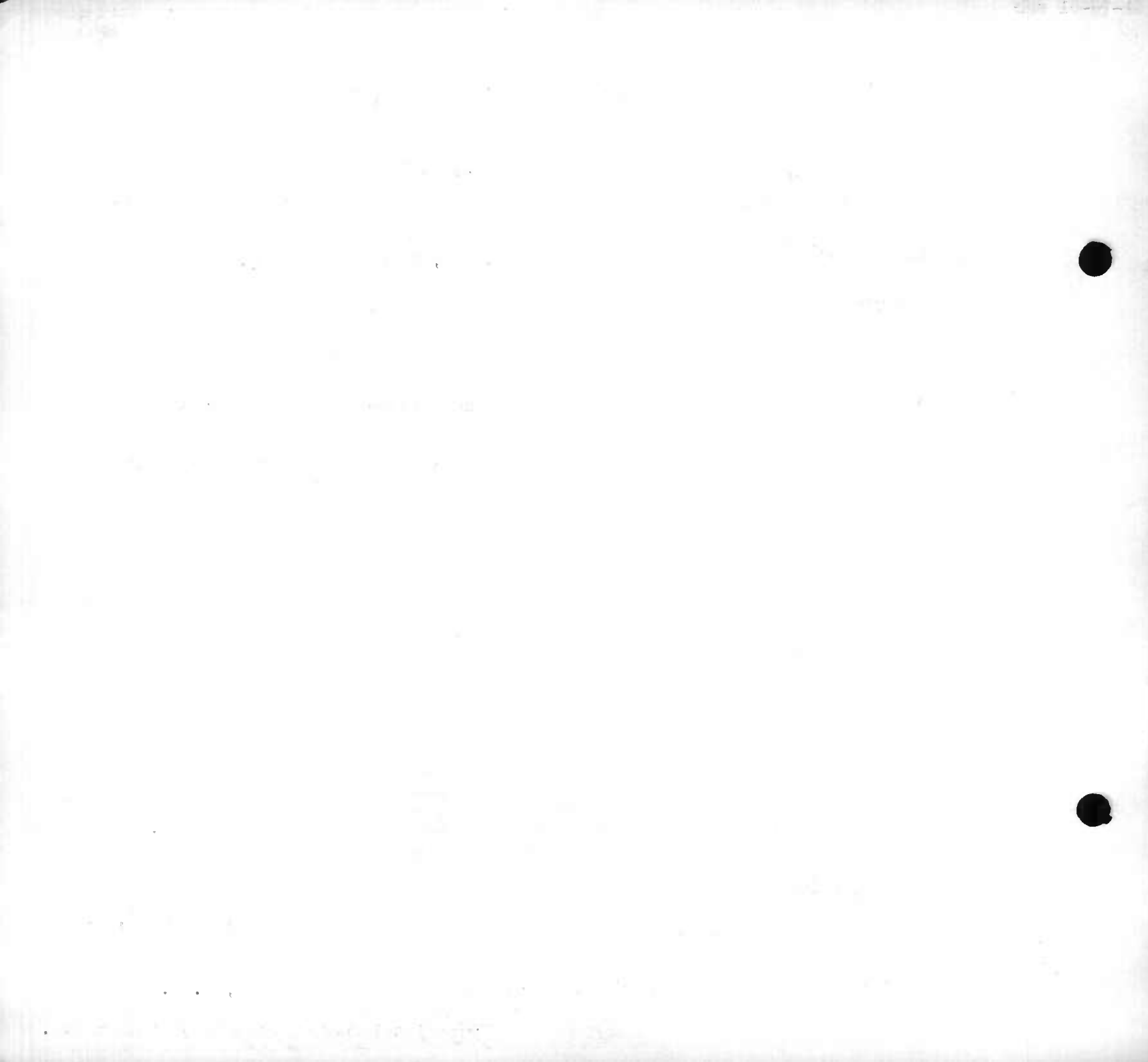
## CERTIFICATE OF DEATH

REG. NO. 70 00793

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Homer Monroe Burkett</b>		2. DATE AND HOUR OF DEATH <b>1/20/70 at 12:15 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 EASTERN AVE.</b>		C. CITY OR TOWN <b>Essex 21221</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>912 BARREN AVE.</b>		21221	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1876</b>	9. AGE (In years last birthday) <b>93</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE BURKETT</b>		14. MOTHER'S MAIDEN NAME <b>SARAH SCHNEIDER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>067-30-1377A</b>		17. INFORMANT <b>MARGARET REPAIR</b> Records: BCH-4940 Eastern Avenue 21224	
18. <b>151.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Stomach</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/3/1969</b> to <b>1/20/1970</b> that (I) (we) last saw the deceased alive on <b>1/20/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. B. Rao</b>		23B. DATE SIGNED <b>1/20/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>D. B. RAO</b>		23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Md. 21224</b> <b>BALTIMORE CITY HOSPITAL, 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Niagara Falls, N. Y.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Brudzinski Funeral Home</b> 1407 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

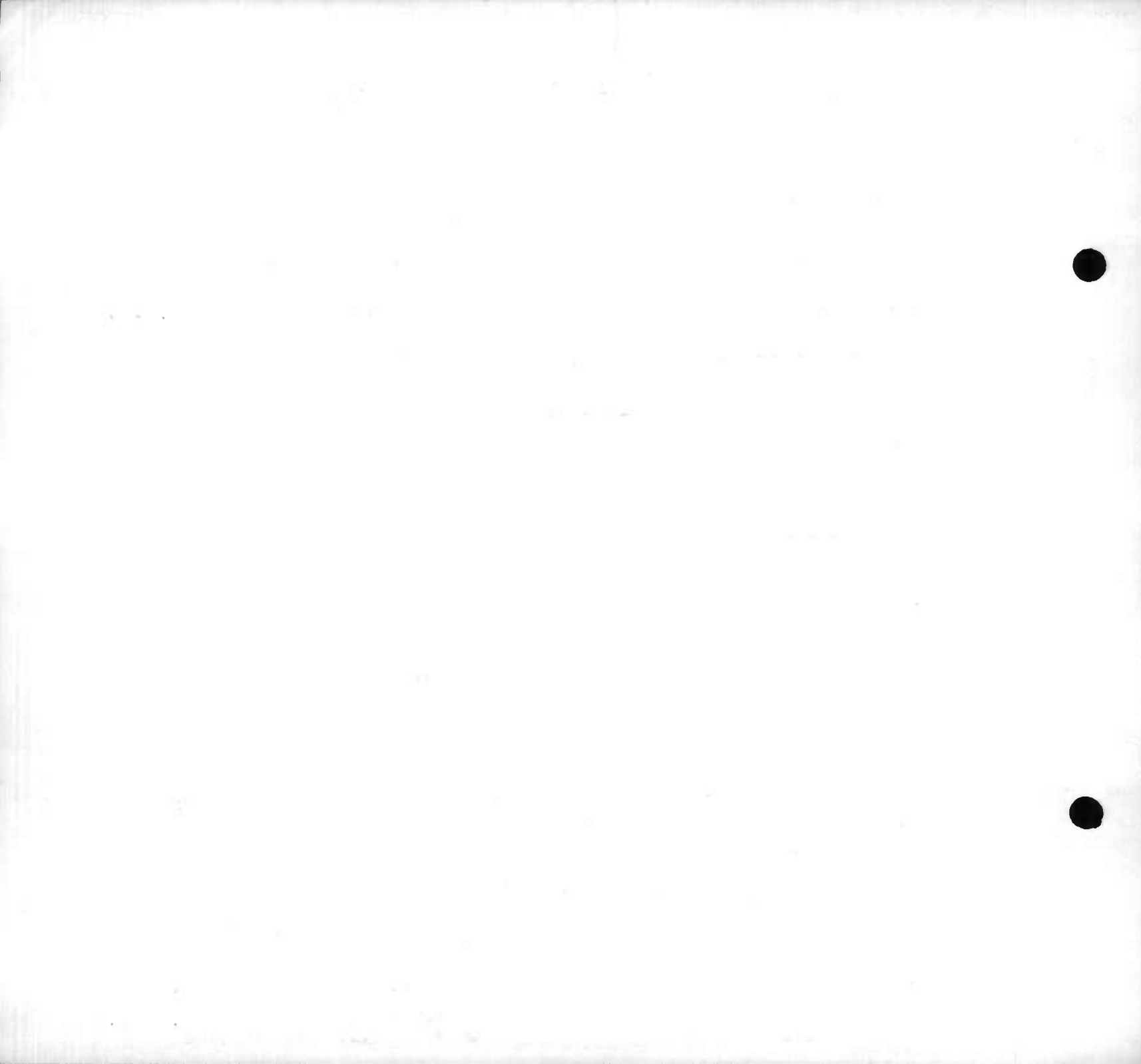
N-120 1		70 00794		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00794	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY M. NOVAK</b>				1/19/70 1 5 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2404 ERDMAN AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/20</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE Steno. Tel. Answering Ser</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES HENNEGAN</b>				14. MOTHER'S MAIDEN NAME <b>EBELLE RETHMAN.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-16-5422</b>		17. INFORMANT <b>MR. EDWIN NOVAK</b>		ADDRESS <b>2404 ERDMAN AVE</b>	
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>intra cerebral hemorrhage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>M2M</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/7</b> 19 <b>70</b> to <b>1/19</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/19</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anne L. Leddy M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Anne L. Leddy M.D.</b>				23D. ADDRESS <b>Union Memorial Hosp. Baltimore Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schmuneck Funeral Home, Inc.</b>		ADDRESS <b>73331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00795	
BIRTH NO. 70 00795		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BERTHA or Bozena PARIZEK</b>		2. DATE AND HOUR OF DEATH <b>1/19/70 12<sup>05</sup> A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <b>1605 E. 30th Street.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/01/95</b>	9. AGE (in years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>NOT KNOWN</b>			
14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-36-8808</b>			
16. SOCIAL SECURITY NO. <b>212-36-8808</b>		17. INFORMANT <b>MR. MILTON PARIZEK, 1907 LONGVIEW AVE.</b>			
18. <b>427.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardio - respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>probably 2° to myocardial failure and Sepsis.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>12/20</b> 19 <b>69</b> to <b>1/19</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anne L. Leddy M.D.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian National Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>23 1970</b>		25B. NAME OF REGISTRAR <b>228 E. Federal St.</b>	
25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>		25D. ADDRESS <b>3331 Brehms Lane</b>		25E. DATE <b>1/23/70</b>	



51-10-63

js

H-230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 00796

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Blanche Hockett

2. DATE AND HOUR OF DEATH

Jan 18, 1970 3:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospital  
4940 Eastern Ave., Balto., Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1025 Rodman Way, Balto., Md. 21205

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-6-11

9. AGE (In years  
last birthday)

58

If Under 1 Tr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Texas Kentucky

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Al Clevenger

14. MOTHER'S MAIDEN NAME

Rosann Mullins

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-26-3753

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Multiple myeloma.

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

12 HRS.

2 yrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Candida sepsis

19A. DATE OF OPERATION

20A. AUTOPSY? (Yes or No)

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?YES ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-10-69 19 to 1-18-70  
that (I) (we) last saw the deceased alive on 1-18-70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hubert W. Gerry M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

Jan 18, 1970

23C. PHYSICIAN'S  
NAME (Type)

Hubert W. Gerry M.D.

23D. ADDRESS

4940 Eastern Ave., Balto., Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/22/70

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

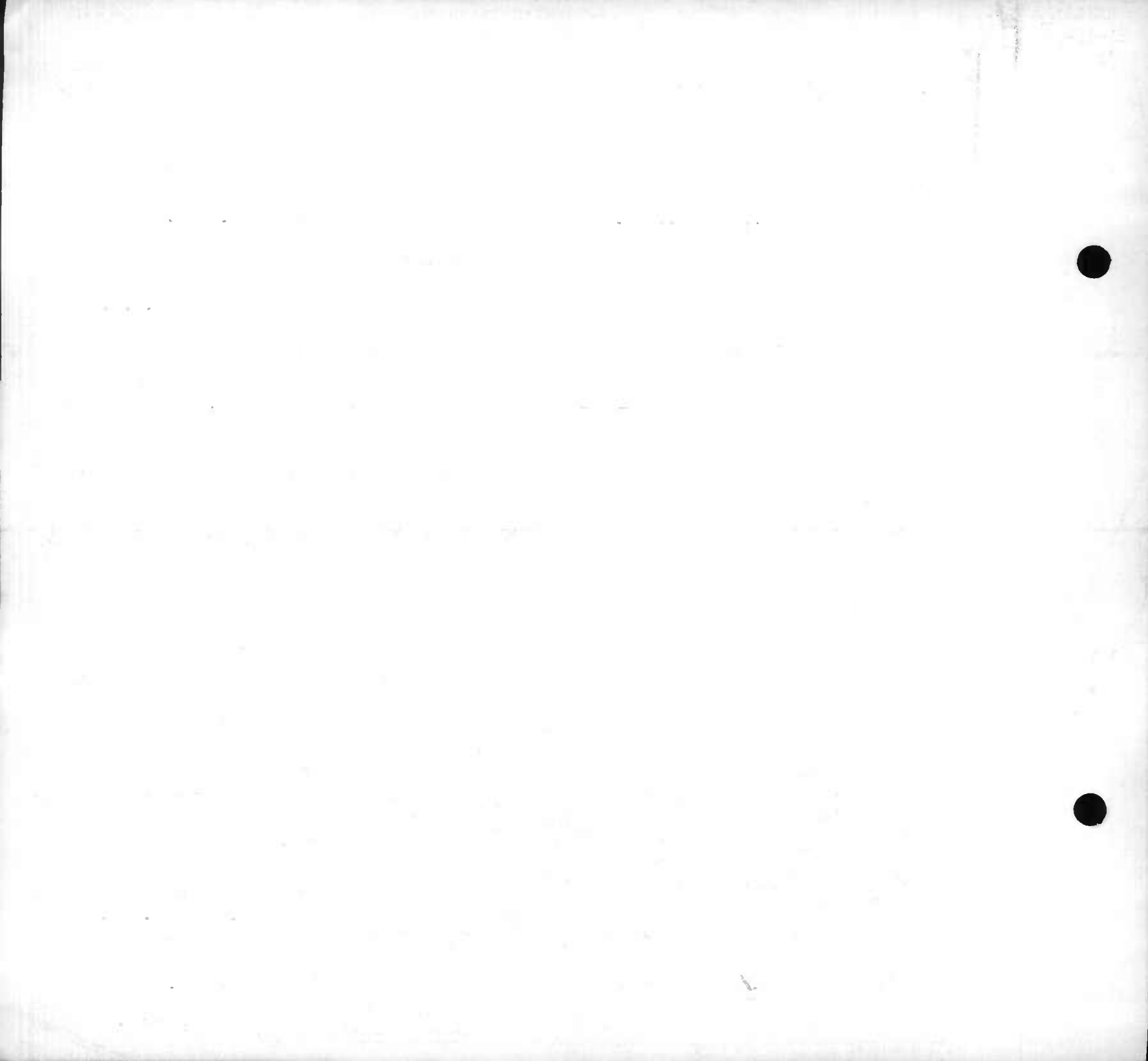
Robert E. Taber M.D.

25C. FUNERAL DIRECTOR

Schmunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Phillip Frank PHILLIP WENDLING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>HOPKINS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1970 5:00 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>602</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/31/1903</b>		10. AGE (In years last birthday) <b>66</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Perfect Radiator</b>	
15. MOTHER'S MAIDEN NAME <b>unknown</b>		13. FATHER'S NAME <b>Peter Wendling</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Ca therine Freitag Wendling, wife, above</b>		ADDRESS	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/70</b> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3931 Bragms Lane</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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WASHINGTON, D. C.

WASHINGTON, D. C.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

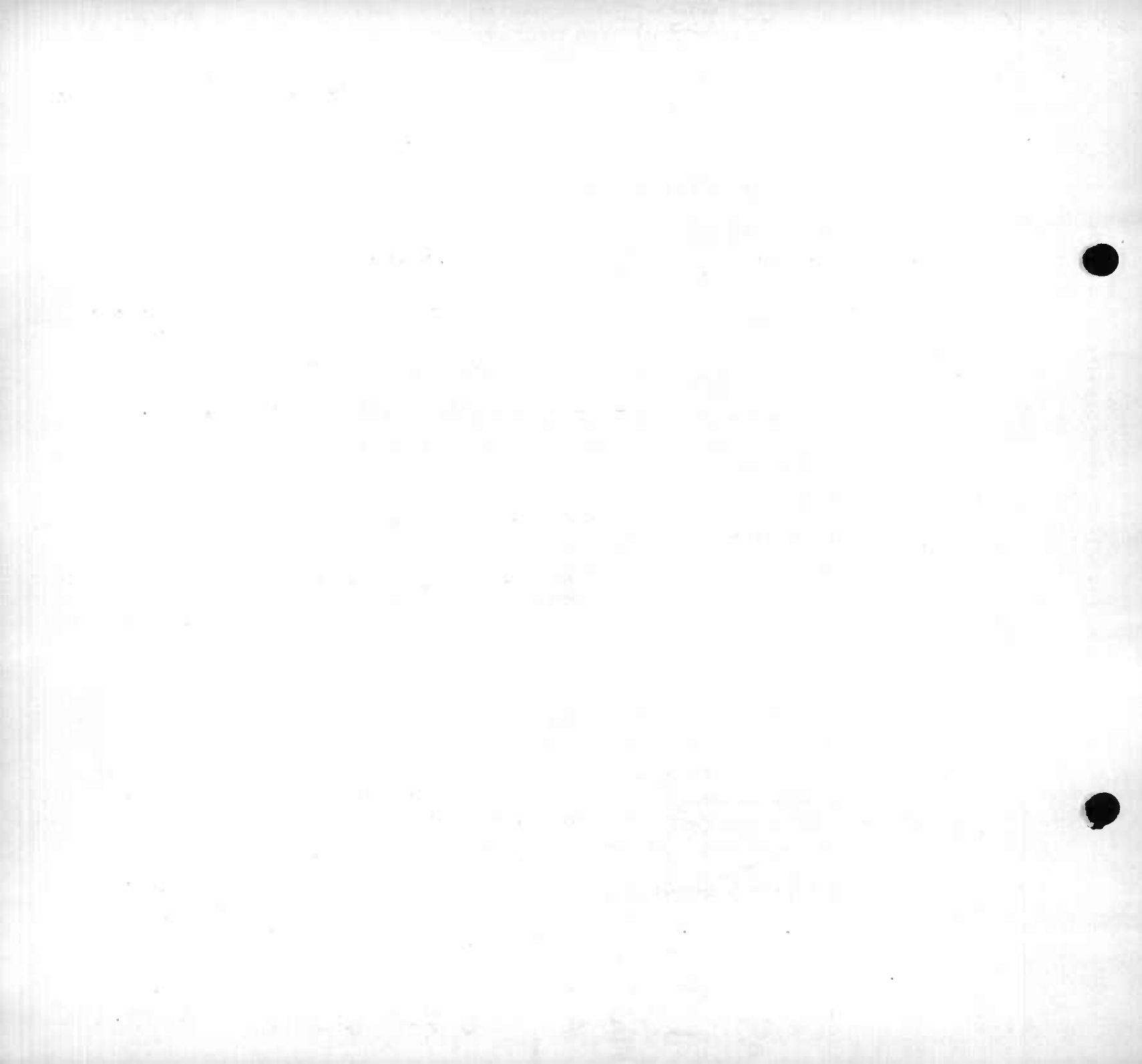
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 00798		70 00798		70 00798	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CLARENCE L CRAMER		20-Jan-70 1240 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY 904	
43 South Baltimore Gen. Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3028 Reese St		21218	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-02	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lapover-chaufer		10B. KIND OF BUSINESS OR INDUSTRY Balto. City Unknown		11. BIRTHPLACE (State or foreign country) W. Va	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Martin CRAMER		14. MOTHER'S MAIDEN NAME Jennie F. Cox(?)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Brother - Chester Cramer - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4/10/91		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D.			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 14-Jan 1970 to 20-Jan 1970 that (1) (we) last saw the deceased alive on 20-Jan 1970 and that (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Richard E Fisher M.D.		23B. DATE SIGNED 20-Jan-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard E Fisher M.D.		South Baltimore Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 1/23/70	24C. NAME OF CEMETERY OR CREMATORY Hopland Mem. Park	24D. LOCATION (City, town, or county)	(State)	
Burial			Baltimore, Md.		
25A. DATE DEATH CERTIFICATE PREPARED JAN 23 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schlunk Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 00799		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00799	
1. NAME OF DECEASED (Type or Print) <b>KRISTINA BUCSURICS</b>				2. DATE AND HOUR OF DEATH <b>Jan. 19, 1970</b>   <b>5:30 p.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21206</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>6120 Ridgeview Avenue</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 13, 1891</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cech</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-0436D</b>		17. INFORMANT <b>Miss Doris Bucsurics, dght. above</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY ATHEROSCLEROSIS</b>		<b>20 years</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF:				<b>20 years</b>	
		(C) <b>Atherosclerosis, generalized</b>					
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>Feb. 24, 1954</b> to <b>Jan. 19, 1970</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>Nov. 19, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Adam G. Swiss</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Jan. 20, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Adam G. Swiss</b>				23D. ADDRESS <b>6232 Belair Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

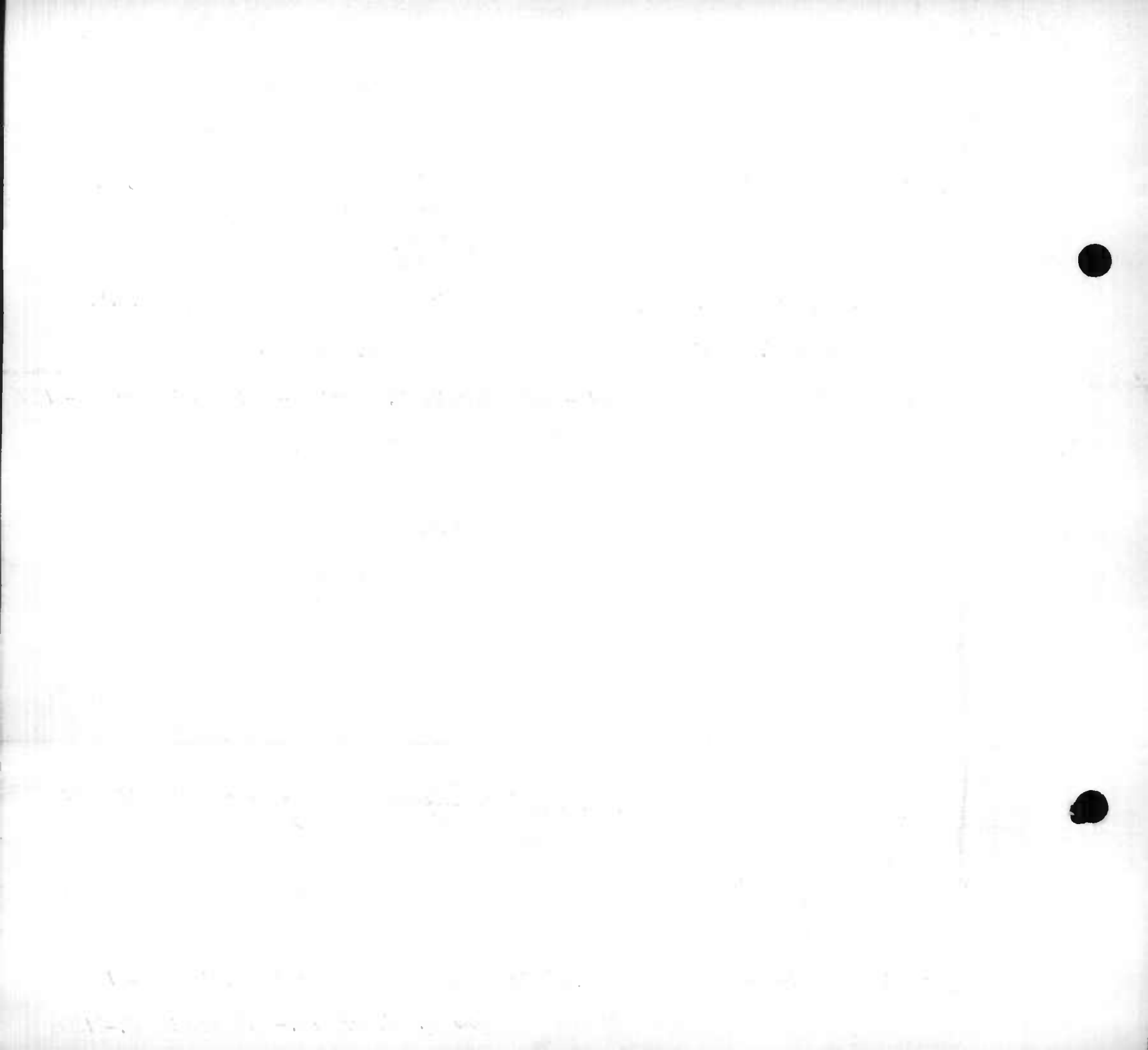
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 00800</b>
BIRTH NO. <b>70 00800</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>SANTA-R. THATER</b>		2. DATE AND HOUR OF DEATH <b>1-20-70 5:05 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2611</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTIMORE INC.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11-1-10</b>		9. AGE (In years last birthday) <b>59</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Straw Hat Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Levy Bros.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13. FATHER'S NAME <b>Paul Reina</b>		
14. MOTHER'S MAIDEN NAME <b>Rose Musuman</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-05-9057</b>		
16. SOCIAL SECURITY NO. <b>212-05-9057</b>		17. INFORMANT <b>Shirley Naish, neice, 3504 Richmond Av</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>174 X I METASTATIC CARCINOMA OF THE LEFT BREAST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 YEARS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1-10-1970</b> to <b>1-20-1970</b> that (I) (we) last saw the deceased alive on <b>1-20-1970</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>PRASID VONKESNAKORN</b>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>PRASID VONKESNAKORN</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		
25B. NAME OF REGISTRAR <b>E. J. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>Funeral Home, Inc.</b>		
25D. ADDRESS <b>3331 Brehms Lane</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 00801		70 00801		70 00801	
1. NAME OF DECEASED (Type or Print) <u>Robert D. Herrick</u>			2. DATE AND HOUR OF DEATH <u>19 JAN 1970 6<sup>10</sup> A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>42</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>6013 Ewirth Ave</u> <u>2631</u>					
5. SEX <u>M</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/13</u>	9. AGE (in years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>State Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph F. Herrick</u>			
14. MOTHER'S MAIDEN NAME <u>Maude Fullmer</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>705-10-2406</u>		17. INFORMANT <u>Dorothy V. Herrick - 6013 Ewirth Avenue-21206</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>GRAM Negative Sepsis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GRAM Negative Pneumonia</u> <u>Chronic obstructive Lung disease</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>30 Dec 1969</u> to <u>19 JAN 1970</u> that (we) last saw the deceased alive on <u>19 JAN 1970</u> and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE <u>Morris Ostroff, MD</u>			23B. DATE SIGNED <u>19 JAN 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>MORRIS Ostroff, MD</u>			23D. ADDRESS <u>Sinai Hospital of Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-22-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland-21206</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>			
25B. NAME OF REGISTRAR <u>John C. Miller Inc.</u>		25C. FUNERAL DIRECTOR <u>4615 Belair Rd.-21206</u>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

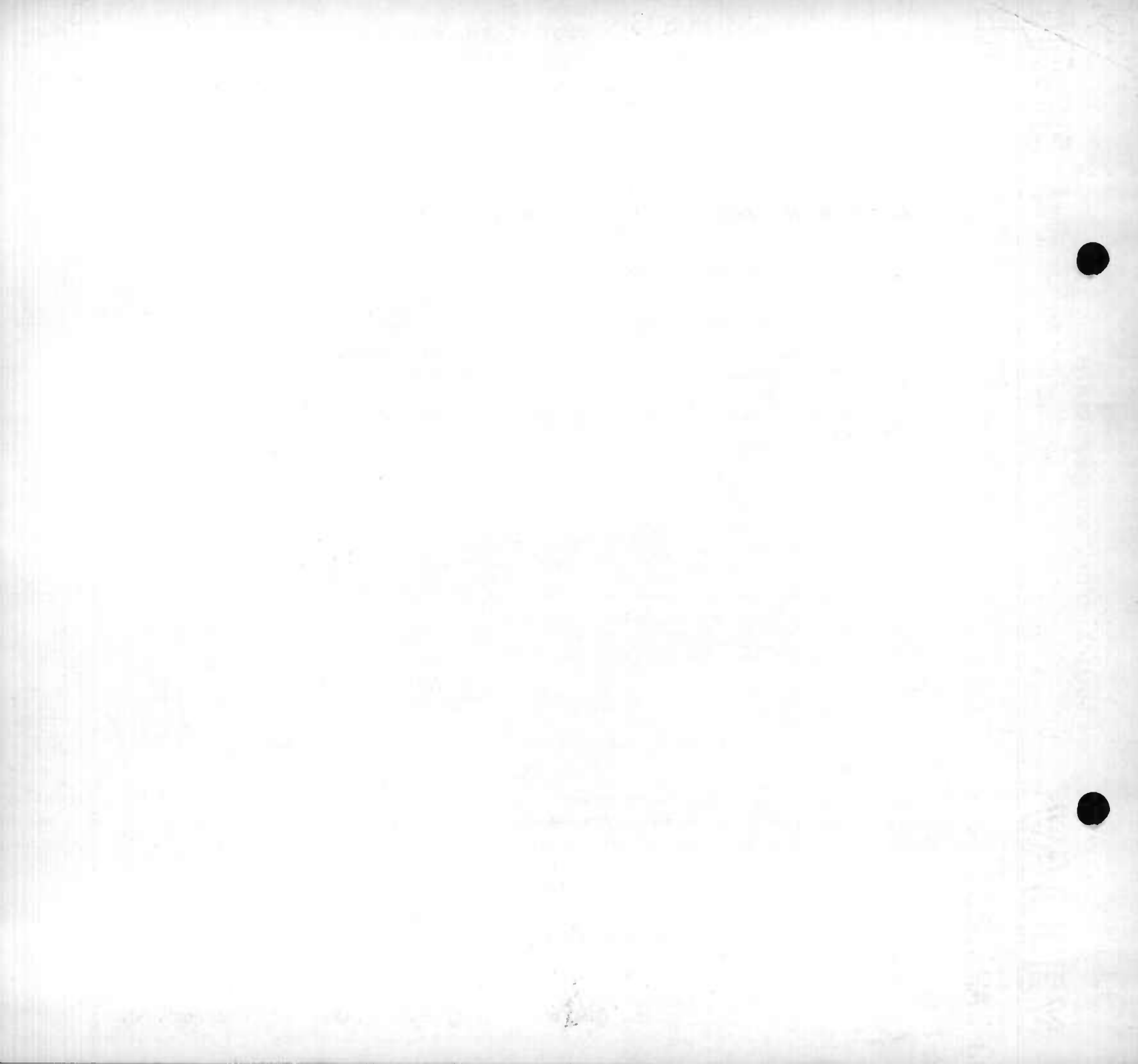
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 00802</b>	
70 00802				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>GORSKI, Joseph MN</b>				1-15-70 11:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>602</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5-15-92</b> 9. AGE (In years last birthday) <b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>				11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alexander Gorski</b>				14. MOTHER'S MAIDEN NAME <b>Victoria</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7-19-17 to 6-6-19</b>				16. SOCIAL SECURITY NO. <b>215-09-35-20</b>	
17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>Baltimore, Maryland 21218</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1621 I Carcinoma of lung with cerebral Metastases suspected</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized arteriosclerotic vascular disease</b> Years (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>Urinary tract infection 2 Degrees BHP</b> Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>December 1, 19 69</b> to <b>January 15, 19 70</b> , that <b>X</b> (we) last saw the deceased alive on <b>January 15, 19 70</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) ( <del>do not</del> ) view the body after death.					
23A. SIGNATURE <b>Marcia C. Schmidt, M.D.</b> DEGREE <b>M.D.</b>				23B. DATE SIGNED <b>1-16-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Marcia C. Schmidt, M. D.</b> DEGREE				23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/19/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Bernard A. Dabrowski</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

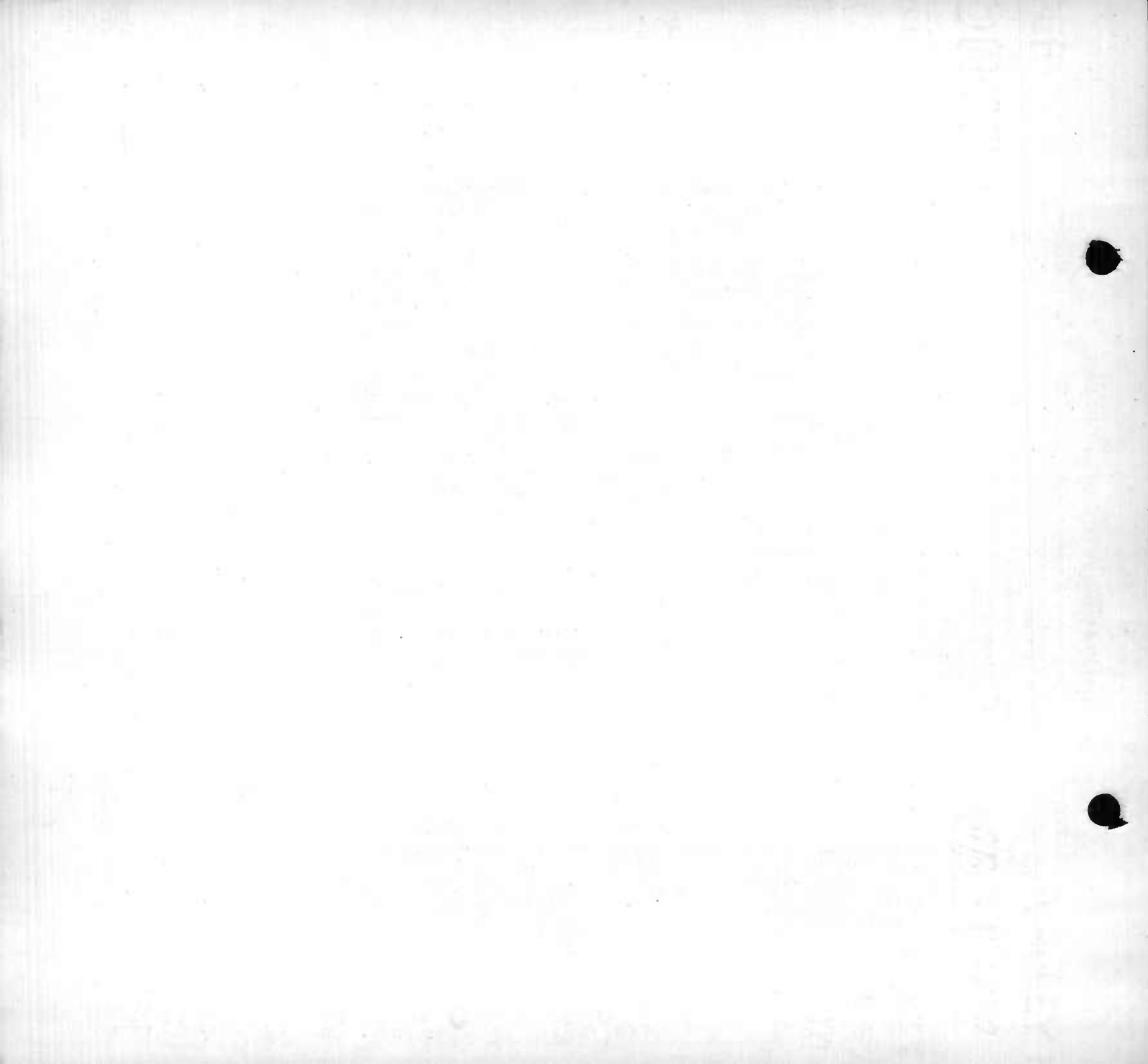
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00803</u>	
BIRTH NO. <u>70 00803</u>				<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>LORRAINE R. DOUGLAS</u>			2. DATE AND HOUR OF DEATH <u>1-20-70 12:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL OF MARYLAND</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1509</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3717 CHESHLOM RD</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-53</u>	9. AGE (In years last birthday) <u>16</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Douglas</u>			14. MOTHER'S MAIDEN NAME <u>Tamatha Martin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Tamatha M. Douglas - 3717 Cheshlom Road</u>
18. <u>2829 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hemolytic Crisis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic hemolytic anemia (undetermined etiology)</u> (C) <u>Acute viral illness</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> 19 <u>70</u> to <u>1-20</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Violeta R. Gamara R.</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>VIOLETA R. GAMARRA R. M.D.</u> DEGREE				23D. ADDRESS <u>730 Ashburton St. Bal. Md 21216</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-24-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, D.D.</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00804
BIRTH NO. 70 00804		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>SELINA MEDINA, Junior</b>		2. DATE AND HOUR OF DEATH <b>8:30 A.M. 1-19-70</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>730 ASHBURTON ST. BALTIMORE MD 21216</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>15-18</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3919 BOARMAN AVENUE</b>				
5. SEX <b>F.</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-01</b>	9. AGE (In years last birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>David Gentry</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-54-6768</b>		17. INFORMANT <b>Lillian Griffin - 3919 Boarmen Ave.</b>
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>PNEUMONIA BILATERAL</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ARTERIO-SCLEROTIC HEART DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>CHRONIC BRAIN SYNDROME</b>				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12-31-1969</b> to <b>1-19-1970</b> , that (I) (we) last saw the deceased alive on <b>1-19-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Prem Lal M.B.B.S.</b>		23B. DATE SIGNED <b>1-19-1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>PREM LAL M.B.B.S.</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>730 ASHBURTON ST. BALTIMORE MD. 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-22-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>	25C. FUNERAL DIRECTOR <b>Charles R. Law</b> ADDRESS <b>802 Madison Avenue</b>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

CAROLYN STRONG

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

8:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

8:45 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Negro

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

March 8, 1965

10. AGE (In years  
last birthday)

4

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

433 Cummings Court

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ulysses Strong

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Alice Henderson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Alice H. Strong - 433 Cummings Court

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Acute purulent tracheobronchitis  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Psychomotor retardation

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
YES22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-22-70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

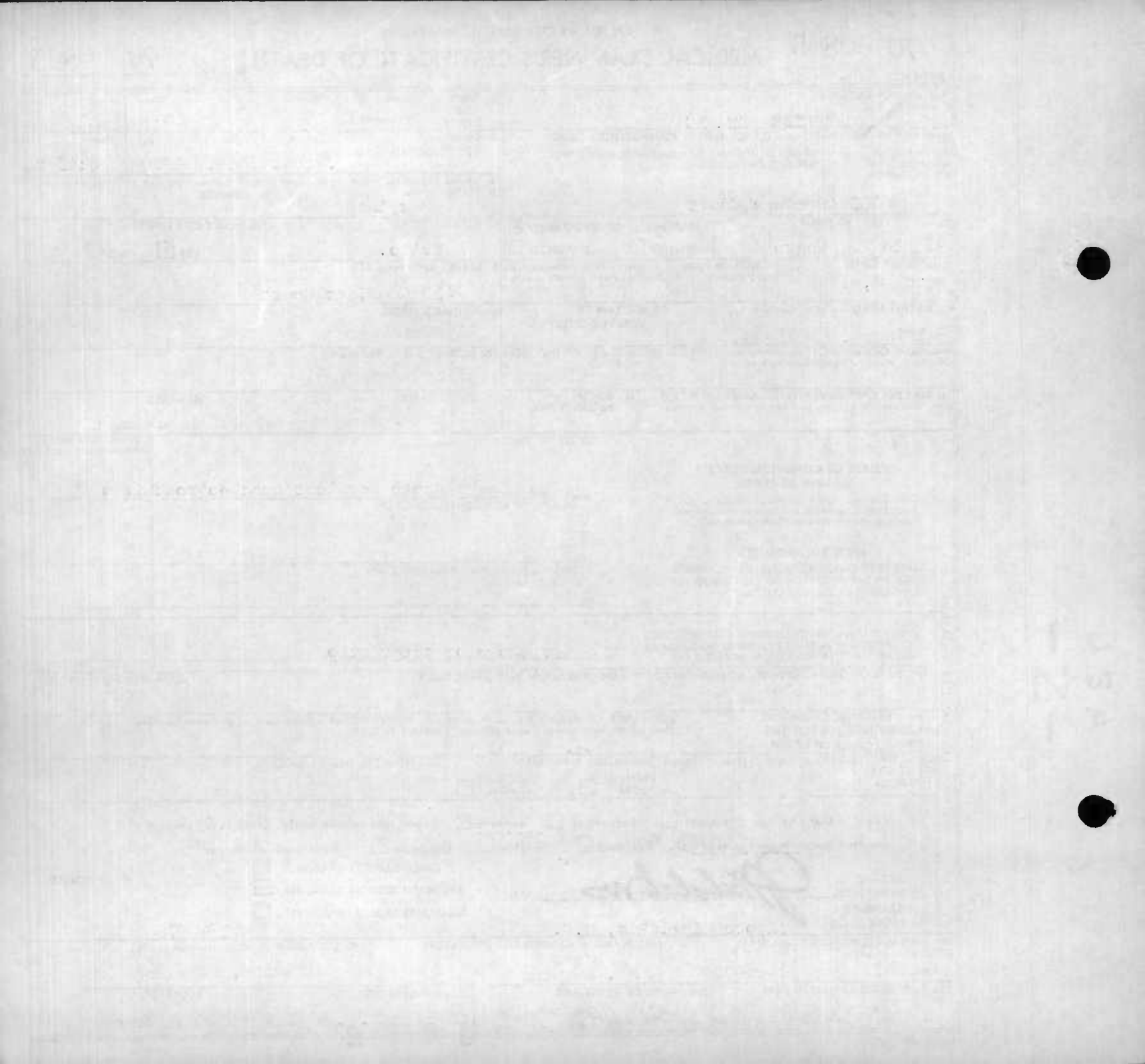
25B. NAME OF REGISTRAR

Isidore Mihalakis, M.D.

25C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Avenue

ADDRESS



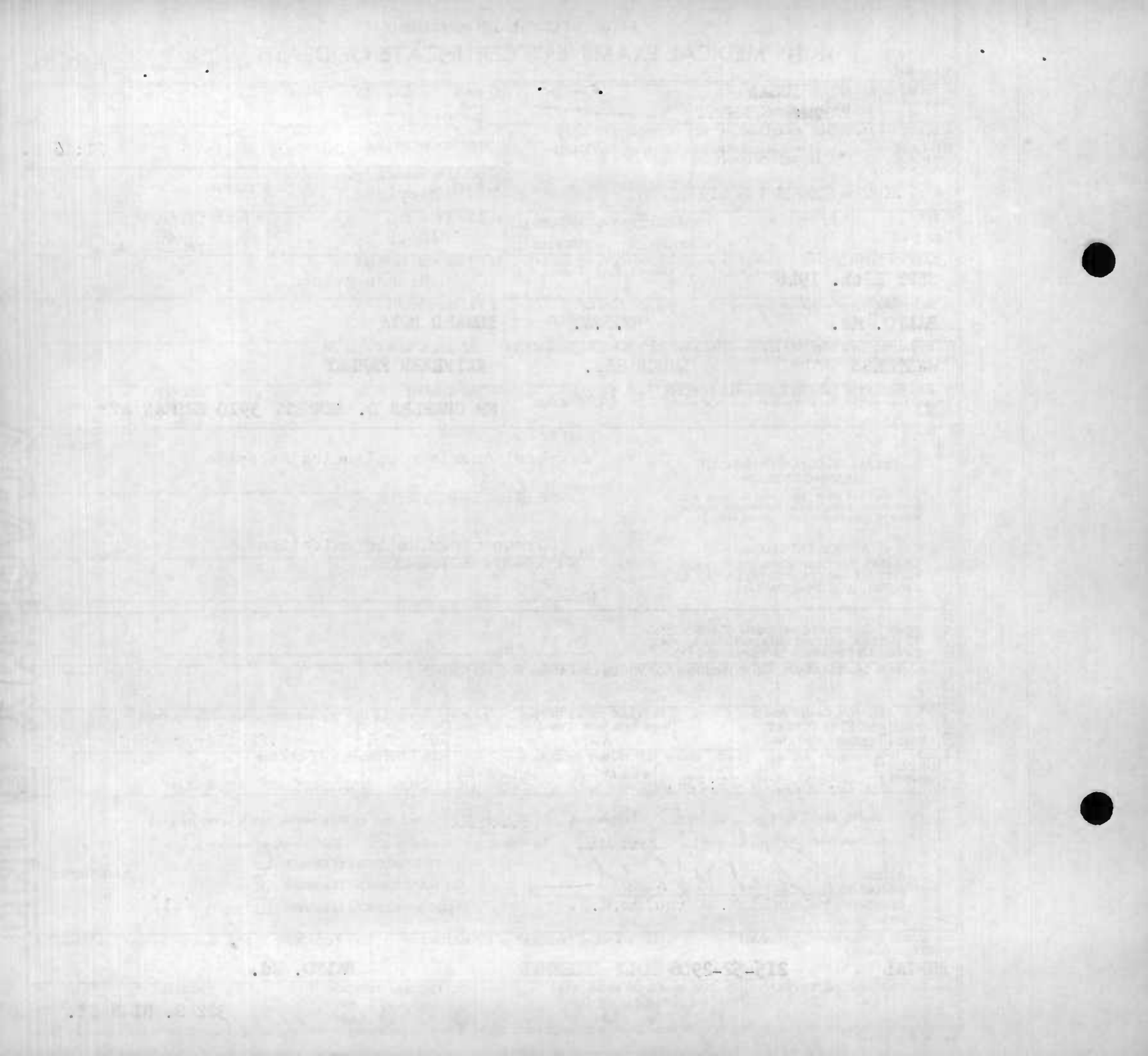


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00806

BIRTH NO. 70 00806

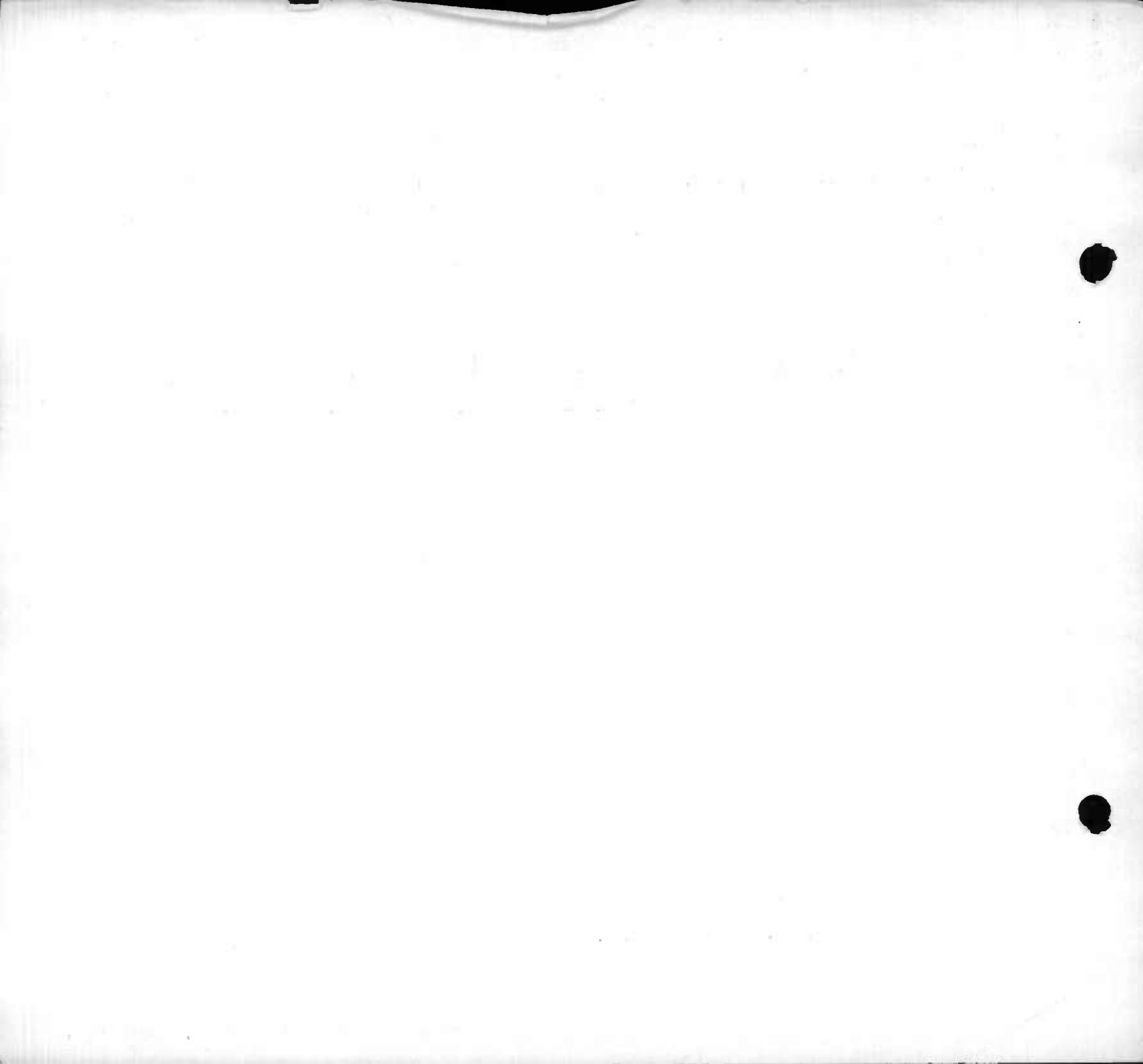
1. NAME OF DECEASED (Type or Print) <b>SUSAN PAMELA SENNETT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL OR INSTITUTION ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1970 11:15 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>SEPT 11th. 1948</b>		10. AGE (In years most birthday) <b>21</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b>		12. CITIZEN OF <b>USA, COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>LUNCH RES.</b>	
15. MOTHER'S MAIDEN NAME <b>KATHEEN FARLEY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>MR CHARLES D. SENNETT 3910 ERDMAN AVE</b>	
19. <b>E 873</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Anoxia complicating Asphyxia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carbon monoxide intoxication</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Auto</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>5912 Pulaski Hwy. (Philip's 66 Gas Station)</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>Jan. 17, 1970 11:53A. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Found unconscious in auto</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>215-52-2906</b>	
24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>E. J. Barker, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Edith D. Vane</b>		ADDRESS <b>322 S. HIGH ST.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

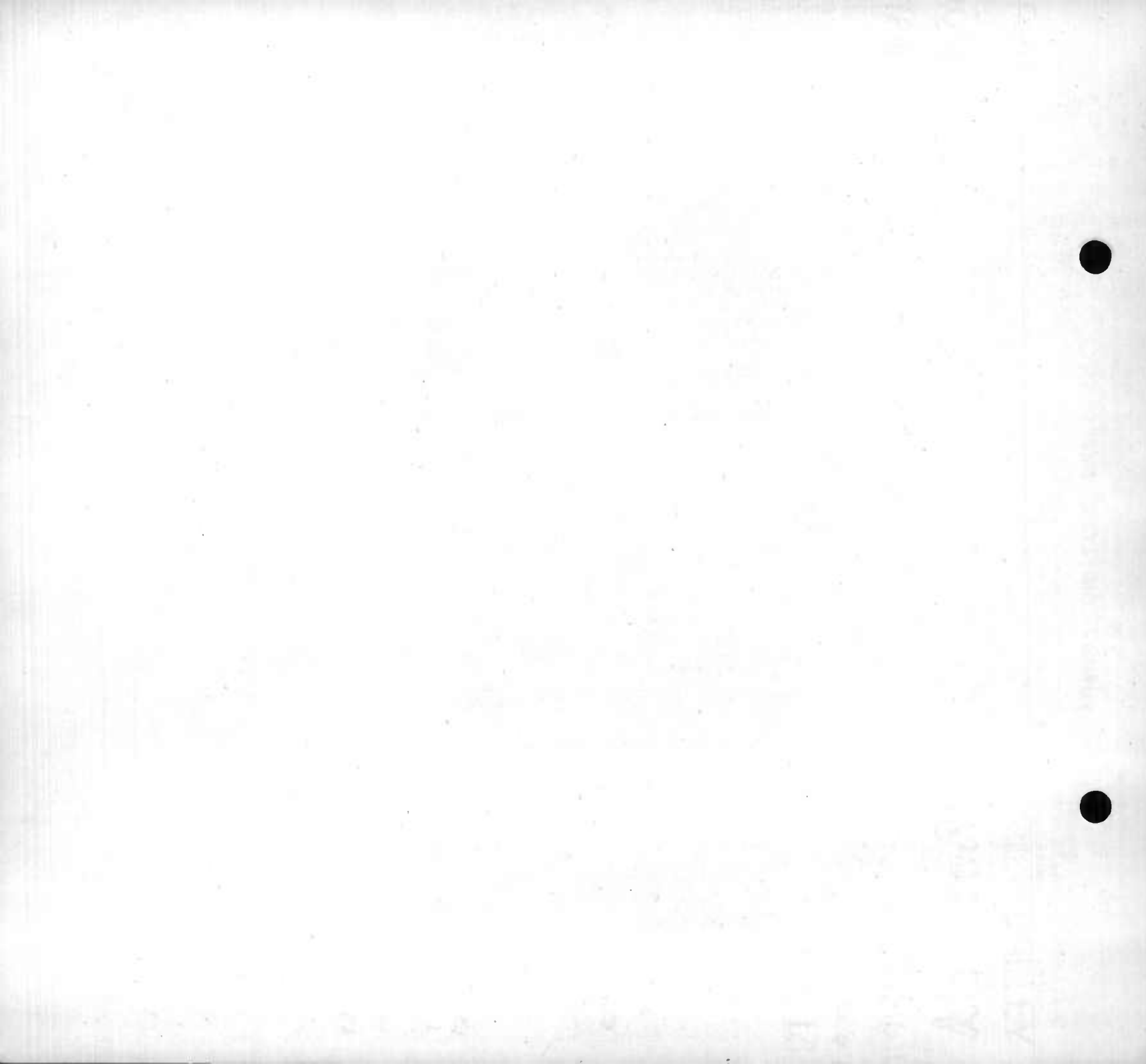
BIRTH NO. 70 00807				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00807	
1. NAME OF DECEASED (Type or Print) VIRGINIA ROSS				2. DATE AND HOUR OF DEATH 1-19-70 3:30P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND		B. COUNTY 14-02	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1421 DRUID HILL AVENUE							
5. SEX FEMALE	6. RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-13-25	9. AGE (in years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Percy Green				14. MOTHER'S MAIDEN NAME Estelle Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-20-6428		17. INFORMANT Dr. Benjamin C. Ross, Sr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 426X I Pulmonary Hypertension and Cor Pulmonale				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/10 1970 to 1/19 1970 that (1) (we) last saw the deceased alive on 1/19 1970 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. S. ARONSON, M.D.				23B. DATE SIGNED 1/19/70			
23C. PHYSICIAN'S NAME (Type) R. S. ARONSON M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-70		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR Robert E. Barber, Jr.		25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00808				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00808			
1. NAME OF DECEASED (Type or Print) <i>Harris, Cecile.</i>				2. DATE AND HOUR OF DEATH <i>1. 22. 70 11:55 p.m.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>46 LUTHERAN HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-06</i>							
5. SEX <i>FEMALE</i> 6. RACE <i>NEGRO</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>5-29-05</i> 9. AGE (In years last birthday) <i>64</i>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>				11. BIRTHPLACE (State or foreign country) <i>MD</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Joseph Harris</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Hill</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO.							
17. INFORMANT <i>Hoyt E. Harris</i>				ADDRESS <i>2903 Presbury St</i>							
18. <i>436.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Bilateral Basal Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>CVA with R-hemiplegia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)							
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>1-10-70</i> to <i>1-22-70</i> , that <i>(I)</i> (we) last saw the deceased alive on <i>1-22-70</i> and that <i>in</i> (my) <i>(aut)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(We)</i> (did) (did not) view the body after death.											
23A. SIGNATURE <i>G. Nanes</i> M.D. DEGREE				23B. DATE SIGNED <i>1. 22. 70</i>							
23C. PHYSICIAN'S NAME (Type) <i>G. Nanes</i> M.D. DEGREE				23D. ADDRESS <i>Lutheran Hospital 730 Ashburton St - Balto.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/27/70</i>							
24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary</i>				24D. LOCATION (City, town, or county) (State) <i>Brooklyn A A Co MD</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>							
25C. FUNERAL DIRECTOR <i>Hayes</i>				ADDRESS <i>1382 Guilmon St</i>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00809	
70 00809 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William Washington</i>			
2. DATE AND HOUR OF DEATH <i>1/20/70 11<sup>15</sup> pm</i>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>2301</i>	
C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1107 Leadenhall St</i>					
5. SEX <i>Male</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/30/91</i>	9. AGE (In years last birthday) <i>78</i>	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNW</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>UNKNW</i>		11. BIRTHPLACE (State or foreign country) <i>CHARLOTTE N.C</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Washington</i>			
14. MOTHER'S MAIDEN NAME <i>Mann</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>2-14-7741</i>		17. INFORMANT <i>CONA WASHINGTON 1107 Leadenhall St</i>			
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pneumonia Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ASCVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>DAYS</i> <i>YRS</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-13</i> 19 <i>67</i> to <i>1-13</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>1-13</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood, MD</i>				23B. DATE SIGNED <i>1-22-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Donald M. Wood</i>		23D. ADDRESS <i>South Bkto. Gen.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/26/70</i>		24C. NAME of CEMETERY or CREMATORY <i>MA Bursum</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>Donald M. Wood</i>	
ADDRESS <i>638 N. Gilmor St</i>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 1

70 00810

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 00810

01 29 28

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY TYNES</b>		2. DATE AND HOUR OF DEATH <b>JAN 17, 1970 12:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>			A. STATE <b>MARYLAND</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2522 QUANTICO AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/29/28</b>	9. AGE (In years last birthday) <b>41</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ROOSEVELT BOONE</b>		14. MOTHER'S MAIDEN NAME <b>Willie Lee Bröck</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Willie Lee Boone</b>	
				ADDRESS <b>2522 Quantico Ave.</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Respiratory Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe Chronic Obstructive Lung Disease</b>				<b>15+ years</b>	
(B) <b>CHRONIC BRONCHITIS</b>				<b>20 years</b>	
(C) <b>HYPERTENSION</b>				<b>10 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>JAN. 16</b> 19 <b>70</b> to <b>JAN. 17</b> 19 <b>70</b> that (1) (we) last saw the deceased alive on <b>JAN. 17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen C. Achuff</b>				23B. DATE SIGNED <b>January 17, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stephen C. Achuff M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		24E. STATE <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Naber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Gutter Funeral Home</b>	
				ADDRESS <b>3035 W. North Avenue</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00811	
70 00811				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JACQUES, Helen</i>		2. DATE AND HOUR OF DEATH <i>1-17-70 2:15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Calvert</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Bolton Hill Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3371 Madison Ave</i>	
5. SEX <i>F</i>	6. RACE <i>N.</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-15-97</i>	9. AGE (In years last birth day) <i>72</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pvt. Family</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md. U.S.</i>	
13. FATHER'S NAME <i>THOMAS H. SMITH</i>		14. MOTHER'S MAIDEN NAME <i>REBECCA BROWN</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-12-1629</i>		17. INFORMANT <i>MRS. PAULINE HARRIS</i> ADDRESS <i>410 WOODBROOK AVE.</i>	
18. <i>412.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brachycephalic</i> (B) <i>Hypertension CV disease</i> (C) <i>arteriosclerosis generalized</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11/5/70</i> <i>years</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>11/26/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>anastomosis esophagus for adenocarcinoma</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/18</i> 19 <i>69</i> to <i>1/17</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>1/17</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alan H. Macht MD</i>				23B. DATE SIGNED <i>1/17/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>		23D. ADDRESS <i>2 E Real St Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1-21-70</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Unutter Funeral Home</i> ADDRESS <i>3035 W. North Ave.</i>	

14-15-16

17-18-19

20-21-22

23-24-25

26-27-28

29-30-31

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

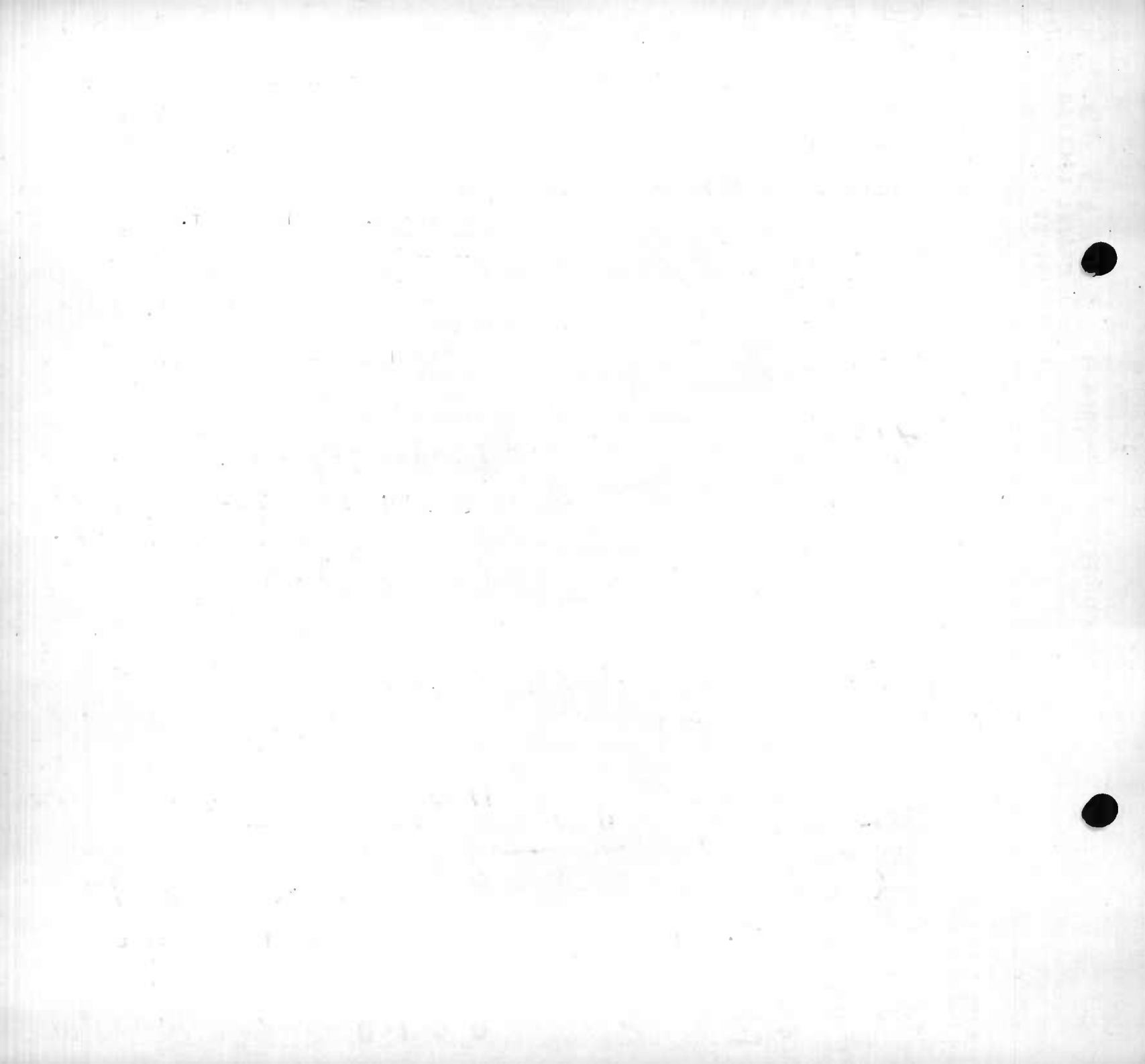
70 00812		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00812	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lula Taylor</i>		2. DATE AND HOUR OF DEATH <i>1/17/70</i> <i>12 30</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2001</i>		C. CITY OR TOWN <i>CITY</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS HOSPITAL BALTO. MD 21223</i>		E. STREET AND NUMBER <i>1802 W LEXINGTON ST. BALTO MD 23</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/26/83</i>	9. AGE (In years last birthday) <i>86</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MAID</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HUTZLER'S</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>AUGUSTUS MARSHALL</i>		14. MOTHER'S MAIDEN NAME <i>WALKER, FANNIE</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Agnes Mitchell 333 B. Suter Road</i>	
18. <i>412.341 E 817X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Fracture of right hip</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>years</i> <i>20 days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Fracture of right hip</i>					
19A. DATE OF OPERATION <i>2/1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1802 W Lexington St 2001</i>	
21D. TIME OF INJURY (APPROX.) <i>12-29-69 7 PM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fell</i>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>12/29</i> 19 <i>69</i> to <i>1/17</i> 19 <i>70</i> that (I) <u>(we)</u> last saw the deceased alive on <i>1/17</i> 19 <i>70</i> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>Orathai Thirawat</i> MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>ORATHAI THIRAWAT</i>		23D. ADDRESS <i>BON SECOURS HOSPITAL, BALTO. MD. 21223</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-20-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 23 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Nutter Funeral Home</i>	
				ADDRESS <i>3035 W. North Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00813
BIRTH NO. 70 00813		70 00813 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) LILLIAN CHASE		2. DATE AND HOUR OF DEATH 1-21-70 1:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2106 E. Biddle St.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-13	9. AGE (In years lost birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard Jackson		
14. MOTHER'S MAIDEN NAME CAROLINE JORDAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 1		
16. SOCIAL SECURITY NO.		17. INFORMANT Howard Chase		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardiac unresponsiveness (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: severe atherosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: coronary disease (C) aortic stenosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)				
19A. DATE OF OPERATION 1/20/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic stenosis		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/20 1970 to 1/21 1970, that (I) last saw the deceased alive on 1/20 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				
23A. SIGNATURE R. Katz		23B. DATE SIGNED 1/21/70		23C. PHYSICIAN'S NAME (Type) R. KATZ
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem.
24D. LOCATION (City, town, or county) (State) Bkts. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00814		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00814	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>SARAH MOORE</b>			2. DATE AND HOUR OF DEATH <b>1/21/70</b> <b>2:10</b> A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hosp</b> <b>33</b>			A. STATE <b>Maryland</b> B. COUNTY <b>704</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>909 N. Caroline Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/02/00</b>	9. AGE (in years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John</b>			14. MOTHER'S MAIDEN NAME <b>Victoria Baker</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Miss Bernice Moore</b>			ADDRESS <b>909 N. Caroline St.</b>		
18. <b>412.21</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <b>Cerebral infarction</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>HASCVD, cellulitis,</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Sepsis, post arrest</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/18/70</b> to <b>1/21/70</b> and that (1) (we) last saw the deceased alive on <b>1/21/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James L. Bolen M.D.</b>				23B. DATE SIGNED <b>1/21/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES L. Bolen M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/24/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>John E. Talbot M.D.</b>	
25C. FUNERAL DIRECTOR <b>John E. Talbot</b>		25D. ADDRESS <b>1129 N. Caroline St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00815		REG. NO. 70 00815	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		John Wesley Brown		1/21/70		1:59 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Friedlers Guest house				Md. 908			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
19 Sep.				E. STREET AND NUMBER			
				2010 Homewood Ave			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
Male	Colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 13, 1894	75	Farmer		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Flam N. C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ashie Brown				Lurenia Ross			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Lessie Johnson		2622 Newton St. NE Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
412.3 I				Pneumonia			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				none			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Nov 6 1969 to Jan 21 1970 that (I) (we) last saw the deceased alive on Jan 21 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Manuel Levin				1/21/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MANUEL LEVIN				6101 PARK HILLS AVE BALTO MD 21225			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/24/70		Mt. Calvary Cem.		Anne Arundel County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 23 1970		J. E. Felt, M.D.		Edith H. Hume		129 n. Calhoun St.	



## CERTIFICATE OF DEATH

REG. NO.

70 00816

BIRTH NO.

70 00816

1. NAME OF DECEASED

(Type or Print)

Nannie Dungee

2. DATE AND HOUR OF DEATH

JANUARY 11, 1970 12:57 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY  
Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2319 Ruth Avenue 21219

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-4-05

9. AGE (In years  
last birthday)

64

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Dungee

14. MOTHER'S MAIDEN NAME

Lizzie ?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
228-30-6893

17. INFORMANT

4940 Eastern Avenue  
BCH Records - Baltimore, Maryland 21224

18. 410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE CARDIORESPIRATORY ARREST  
DUE TO, OR AS A CONSEQUENCE OF:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 HR.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) ACUTE MYOCARDIAL INFARCTION  
DUE TO, OR AS A CONSEQUENCE OF:

36 HR

(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE MANY YR.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY.  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from DECEMBER 30, 19 69 to JANUARY 11, 19 70  
that (1) (we) last saw the deceased alive on JANUARY 11, 19 70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael M. McConnell, M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

JANUARY 11, 1970

23C. PHYSICIAN'S  
NAME (Type)

Michael M. McConnell

23D. ADDRESS

DEGREE

Baltimore City Hospitals  
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/19/70

24C. NAME OF CEMETERY or CREMATORY

Williams Memorial Park

24D. LOCATION

(City, town, or county)

Roanoke, Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR

Herbert E. Nutter 3035 W. North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

JESSE CLARK

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 17, 1970

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital

(DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 17, 1970

4:50 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

HOWARD

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Elkridge

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

5-5-31

10. AGE (In years  
last birthday)

38

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

5790 Race Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jesse C. Clark, Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Brick Mason

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sarah F. Willie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean War

17. SOCIAL  
SECURITY NO.

216-28-9156

18. INFORMANT

ADDRESS

Mrs. Sarah F. Clark 5790 Race Road

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Aorta insufficiency  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 18, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-22-70

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Baltimore,

Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Nutter Funeral Home 3035 W. North Avenue

ACADEMY ISOMID

INT JOURNAL

VALLEY OF THE GODS



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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00818

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LOUIS CALVERT FORD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 17, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 17, 1970</b>		Hour <b>1:45 A.M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>1606</b>		
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>12-4-34</b>		10. AGE (in years last birthday) <b>35</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		E. STREET AND NUMBER <b>2726 W. Mosher Street</b>
13. FATHER'S NAME <b>Chester Ford</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Company</b>		
15. MOTHER'S MAIDEN NAME <b>Louise Williamson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>Yes</b>		
17. SOCIAL SECURITY NO. <b>212-34-3591</b>		18. INFORMANT <b>Chester Ford</b>		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E812.0</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Bloomingdale Rd. S. of Ellicott Drive</b>
22D. TIME OF INJURY (APPROX.) <b>1-17-70 1:45 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver of car which struck a parked car.</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 18, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>
24D. LOCATION (City, town, or county) (State) <b>Laurel Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Jacobs, Jr. D.O.</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		
25D. ADDRESS <b>3035 W. North Ave.</b>				

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM ARTHUR</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 17, 1970</b>		Hour <b>10:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1601 Park Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 17, 1970</b>		Hour <b>10:00 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>					
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5-27-96</b>		10. AGE (In years last birthday) <b>73</b>		E. STREET AND NUMBER <b>631 N. Carrollton Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>? ?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper-Handler</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Alco</b>		15. MOTHER'S MAIDEN NAME <b>Ella ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-03-8288</b>		18. INFORMANT <b>A Mrs. Lilly E. Arthur</b>	
				ADDRESS <b>631 N. Carrollton Ave</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2 I</b>		CAUSE OF DEATH <b>Hypertensive and arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 18, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>	
				ADDRESS <b>3035 W. North Ave.</b>	

TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]  
DATE : [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]

6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]

16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]

ADDITIONAL INFORMATION

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00820	
BIRTH NO. 70 00820		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LOUIS JOHNSON			2. DATE AND HOUR OF DEATH 1-18-70 8 <sup>20</sup> A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1202		
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GEN. HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3108 BARCLAY ST. 21218		
5. SEX m	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-18-85	9. AGE (In years lost birthday) 84	11. BIRTHPLACE (State or foreign country) St LOUIS UNKNOWN Mo.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas H&E Co		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-4631	17. INFORMANT WIFE - MARY JOHNSON SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.2 I BRONCHOPNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) ENCEPHALOMALACIA (C) HYPERTENSION, ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-15 19 70 to 1-18 19 70, that (I) (we) last saw the deceased alive on 1-18 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angelita A. Topas			23B. DATE SIGNED 1-18-70		
23C. PHYSICIAN'S NAME (Type) ANGELITTA A. TOPAS			23D. ADDRESS MARYLAND GEN. HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park Arbutus Md.	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR Joseph L. Russ		25C. FUNERAL DIRECTOR Funeral Home 2252 N North	
25D. ADDRESS		25E. 21316 Ave			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RICHARD A. CURTIS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 15, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>11 N. Schroder Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 15, 1970</b>		Hour M. <b>8:30 A.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>April 15, 1906</b>		10. AGE (In years last birthday) <b>68.53</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Richard Curtis</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME <b>Mary Lee</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Mr. Leonard Curtis</b>		19. ADDRESS <b>1621 S. Archer St.</b>		
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2/19/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 15, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Westport (Baltimore) Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Joseph E. F. [unclear]</b>
25C. FUNERAL DIRECTOR <b>Joseph E. F. [unclear]</b>		25D. ADDRESS <b>2222 W. North Ave.</b>		

THE NATIONAL BUREAU OF STANDARDS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00822</u>
BIRTH NO. <u>70 00822</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Charles Hill</u>		2. DATE AND HOUR OF DEATH <u>JAN 21 19 170 945 PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1800 E. LANVALE STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-87</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
13. FATHER'S NAME <u>WILLIAM HILL</u>		14. MOTHER'S MAIDEN NAME <u>ELOISE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>251-16-2748</u>		17. INFORMANT <u>Janie Jordan</u> ADDRESS <u>1800 E. Lanvale ST</u>
18. <u>788.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe dehydration</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Severe ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>JAN 21 1970</u> to <u>JAN 21 1970</u> that (I) <del>was</del> lost saw the deceased alive on <u>JAN 21 1970</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>N. F. Adkinson, Jr. MD</u>		23B. DATE SIGNED <u>Jan 21, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>N. F. ADKINSON, JR., M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-26-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Chester, S.C.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>W. C. March 9</u> ADDRESS <u>928 E. North Ave.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00823

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

70 00823

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alice Candy Semmes

2. DATE AND HOUR OF DEATH

January 20, 1970

4:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 100 W. University Parkway

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

100 W. University Pkwy.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

2-13-1886

9. AGE (In years last birthday)

83

10. Under 1 Yr.

Months

Days

Hours

Min.

11. Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward A. Robinson

14. MOTHER'S MAIDEN NAME

Alice Canby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-40-9176

17. INFORMANT

Mr. J. E. Semmes, Jr. Summit, N. J.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DIS.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 YRS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) PARKINSON'S DISEASE

12 YRS

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from

SEPT 20 1961 to

JAN 20 1970

that (1) (we) lost saw the deceased alive on

JAN. 16 1970 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. John M. Scott

23B. DATE SIGNED

1-21-70

23C. PHYSICIAN'S NAME (Type)

Dr. John M. Scott

23D. ADDRESS

600 W. Belvedere Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Cremation

1-21-70

Green Mount Crematory

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

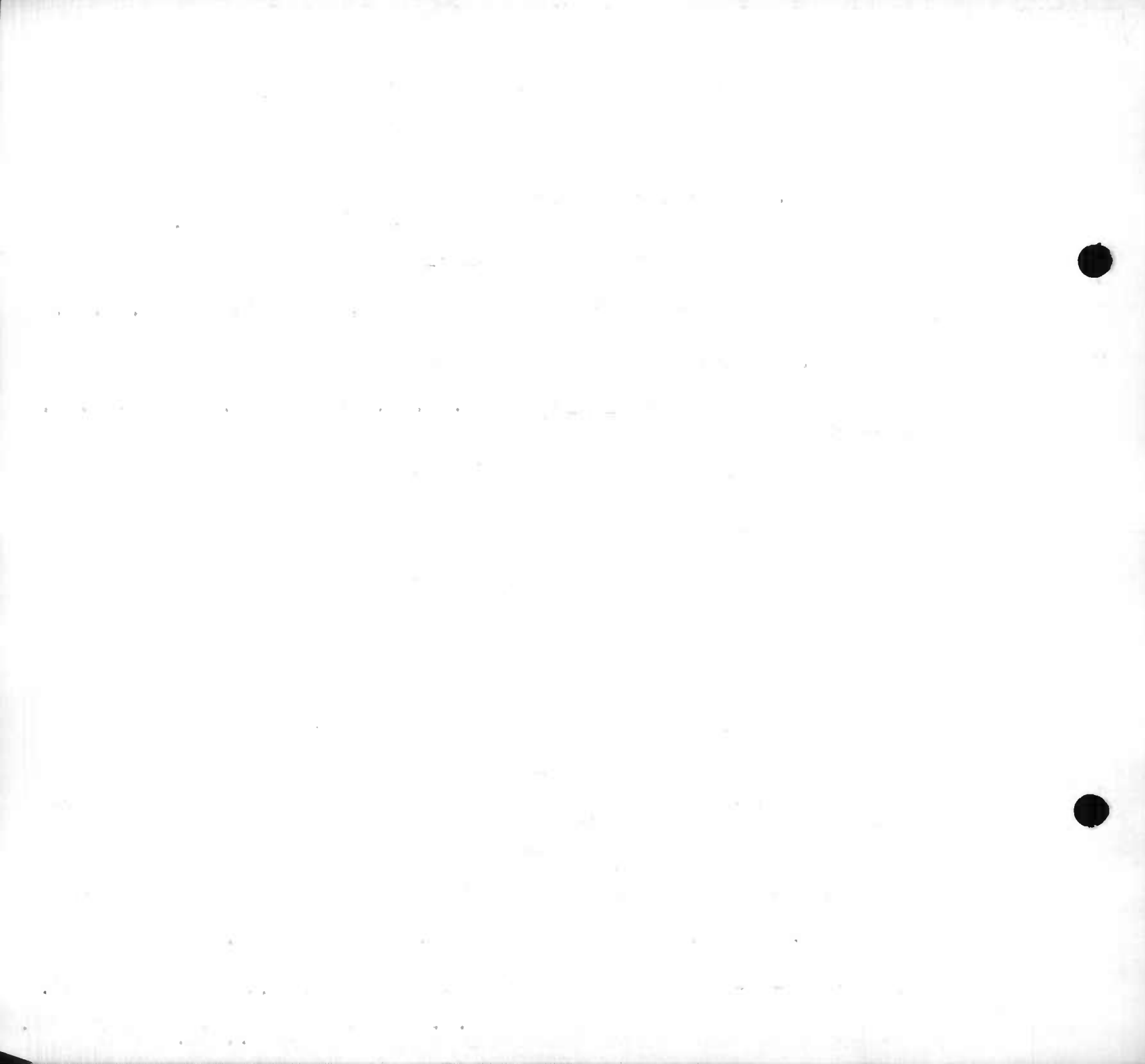
ADDRESS

JAN 23 1970

H.W. Jenkins & Sons Co.

4905 York Rd.

Balto., Md. 21212



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-6301

70 00824

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

70 00824

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNE K. DEWART

2. DATE AND HOUR OF DEATH

JANUARY 21, 1970 12<sup>00</sup> P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

1101

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1001 ST. PAUL STREET

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

MARCH 9, 1898

9. AGE (in years last birthday)

71

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SECRETARY

10B. KIND OF BUSINESS OR INDUSTRY

CHRIST CHURCH

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

LOUIS L. KRAUSS

14. MOTHER'S MAIDEN NAME

HENRIETTA JOCKEL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-01-6502

17. INFORMANT

HARRISON M. ROBERTSON JR. 10 LIGHT ST 21202

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Lymphatic Leucemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Thrombocytopenia 2° to A

6 wks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1945 to 1/21/70 that (I) (we) last saw the deceased alive on 1/20/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francis W. Gluck M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/21/70

23C. PHYSICIAN'S NAME (Type)

Francis W. Gluck M.D.

23D. ADDRESS

100 W University, PKwy

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/23/70

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 23 1970

25B. NAME OF REGISTRAR

Robert E. Talbot, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co.

ADDRESS

4905 York Rd. Balto., Md. 21212



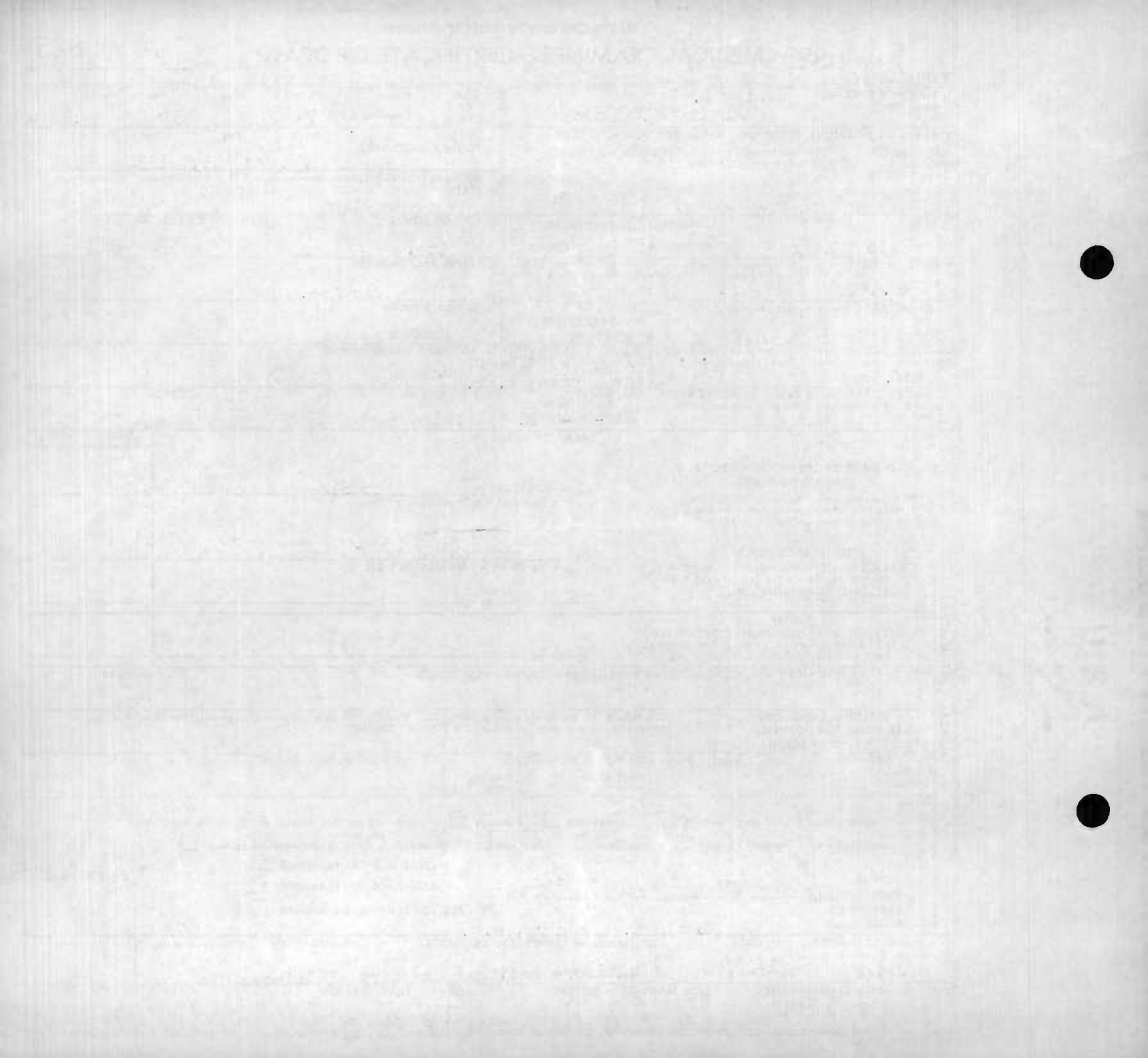
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00825

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Wesley L. Beatty</b> <del>Wesley L. Beatty</del>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 21 70 6:35 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1607 Thomas Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 21, 1970 6:35 a.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2 Feb. 1910		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) Currie North Carolina		12. CITIZEN OF WHAT COUNTRY? American	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef, Cook		15. MOTHER'S MAIDEN NAME Unkown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes War # 2		17. SOCIAL SECURITY NO. 216-05-4718	
18. INFORMANT Estelle Beatty 1607 Thomas Avenue		ADDRESS	
19. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR E. J. S. S. S.	
25C. FUNERAL DIRECTOR Hickson & Wilson Balto. Ct.		ADDRESS 413 W.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00826		CERTIFICATE OF DEATH		70 00826	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				LOSSIE BRILEY		1/20/70 16.45 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND		B. COUNTY 1604			
38 UNIVERSITY OF MARYLAND HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 801 N. MONROE ST. 21217					
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/1/27		9. AGE (In years last birthday) 42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		11. BIRTHPLACE (State or foreign country) ROBINSONVILLE, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME RILEY PERKINS				14. MOTHER'S MAIDEN NAME BLOSSIE -					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. -		17. INFORMANT PHYLLIS BRILEY - SAME AS ABOVE			
18. 20510 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYELOGENOUS LEUKEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH ACUTE MYELOGENOUS LEUKEMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/29 1969 to 1/20 1970 that (I) (we) last saw the deceased alive on 1/20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Andrew M. Doyle				23B. DATE SIGNED 1/20/70					
23C. PHYSICIAN'S NAME (Type) ANDREW M. DOYLE				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

BIRTH NO. 70 00827		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 00827	
1. NAME OF DECEASED (Type or Print) <u>KINZIE, William A.</u>				2. DATE AND HOUR OF DEATH <u>1-22 @ 8:38 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Md. GENERAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2702</u>			
				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2707 Brandon Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-04-90</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK LAYER-CONSTRUCTOR (Retired)</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>NIAGARA FALLS, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>CHARLES H. KINZIE</u>			
14. MOTHER'S MAIDEN NAME <u>RUTHER FORD</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W W T</u>			
16. SOCIAL SECURITY NO. <u>220-02-8786</u>				17. INFORMANT <u>MRS. MABEL S. KINZIE (SAME)</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of the lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <u>JAN 10</u> 19 <u>70</u> to <u>JAN. 22</u> 19 <u>70</u> that <del>(H)</del> (we) lost saw the deceased alive on <u>JAN. 22</u> 19 <u>70</u> and that <del>(H)</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <u>R. W. Schmidt MD.</u>				23B. DATE SIGNED <u>JAN. 22, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. R. W. Schmidt</u>	
23D. ADDRESS <u>Md. General Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/24/70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>			
24D. LOCATION <u>Pikesville, Balto. Co., Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 23 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>H. O. Jenkins &amp; Sons Co.</u>			
25D. ADDRESS <u>4905 York Rd. Balto. Md. 21212</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 00828		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00828	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Mary E. Jahnke		2. DATE AND HOUR OF DEATH January 22, 1970 4:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. City		9-01	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		8. DATE OF BIRTH 02-24-97 9. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) W. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME <del>CLARENCE</del> William Lanier Ward	
14. MOTHER'S MAIDEN NAME <del>LILLIE ANE</del> Lillie Ane Mizell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 213-03-9858T	
17. INFORMANT (Daughter) Husband		ADDRESS Mr. Paul Jahnke (same)		18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory - Cardiac Arrest CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) CVA DUE TO, OR AS A CONSEQUENCE OF: (C) 30 min 2 days	
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the physician)</del> attended the deceased from Jan. 21, 1970 to Jan. 22, 1970 that (I) <del>(the physician)</del> last saw the deceased alive on Jan. 22, 1970 and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(the physician)</del> (did) <del>(the physician)</del> view the body after death.					
23A. SIGNATURE Dr. Ronald V. Gechler		23B. DATE SIGNED Jan. 22, 1970		23C. PHYSICIAN'S NAME (Type) Dr. Ronald V. Gechler	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 23 1970		25B. NAME OF REGISTRAR B. E. Taylor, D.D.	
25C. FUNERAL DIRECTOR H. O. Jenkins Sons Co.		25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212		25E. DATE SIGNED JAN 23 1970	

X

X

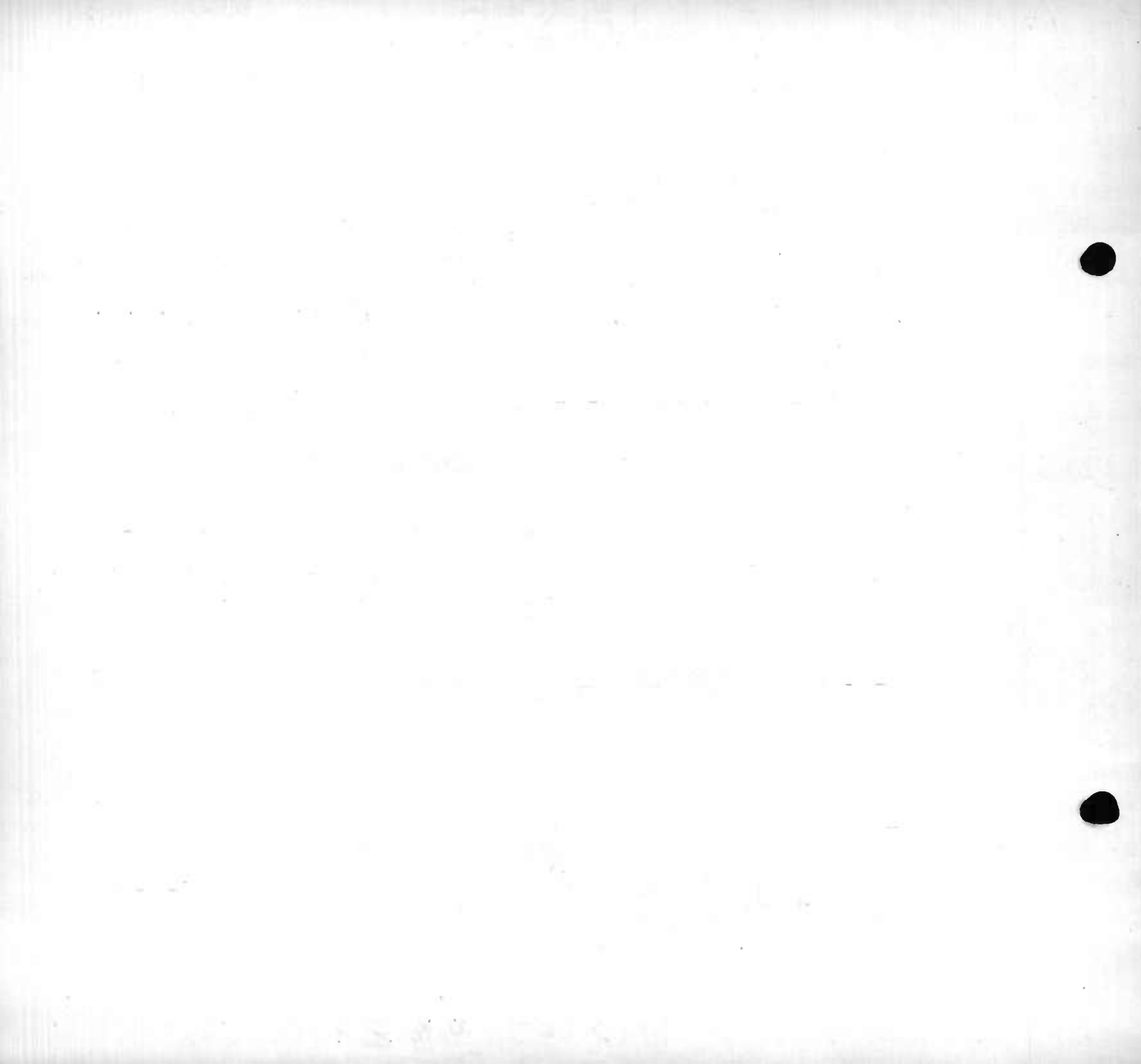
2

X

# FUNERAL DIRECTOR: IMPORTANT

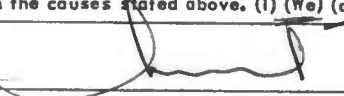
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00829</span>	
BIRTH NO. <span style="float: right;">70 00829</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CHAPPLE, James Bernard</b>			2. DATE AND HOUR OF DEATH <b>21 JANUARY 1970 1:00 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>			C. CITY OR TOWN <b>BALTIMORE 21218</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>CAUCASION</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>5-2-03</b> 9. AGE (In years last birthday) <b>66</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Printer</b>			11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Oscar T. Smith</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>CHARLES CHAPPLE</b>			14. MOTHER'S MAIDEN NAME <b>BRIDGETTE FLYNN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 9-11-42 TO 3-20-43</b>			16. SOCIAL SECURITY NO. <b>218-22-4743</b>		
17. INFORMANT <b>VA HOSPITAL RECORDS</b>			ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>		
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Carcinoma OF COLON</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ESOPHAGEAL VARICES, 2 LITER UGI BLEEDING (NO BLEEDING SITE FOUND)</b> (B) <b>ESOPHAGEAL VARICES, 2 LITER UGI BLEEDING (NO BLEEDING SITE FOUND)</b> (C) <b>ESOPHAGEAL VARICES, 2 LITER UGI BLEEDING (NO BLEEDING SITE FOUND)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>3-4 YEARS</b> <b>24 HOURS</b>					
19A. DATE OF OPERATION <b>10-10-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF COLON</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>20 JANUARY 1970</b> to <b>21 JANUARY 1970</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>21 JANUARY 1970</b> and that in <b>(35)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) <b>(1)</b> (not) view the body after death.					
23A. SIGNATURE <b>John W. Baker MD</b>				23B. DATE SIGNED <b>1-22-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN W. BAKER, MD</b>				23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins Sons Co. 4905 York Rd. Balto.-Md. 21212</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00830		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00830	
1. NAME OF DECEASED (Type or Print) <b>Martin O'Malley Jr.</b>			2. DATE AND HOUR OF DEATH <b>1-21-70 7:30 p.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1627 E. 33rd Street -21218</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>07-09-91</b>	9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-AUDITOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FINANCE CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Maryland U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN O'MALLEY SR.</b>		14. MOTHER'S MAIDEN NAME <b>E. Frances OWENS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-3585</b>		17. INFORMANT <b>MRS. ANNIE M. O'MALLEY (SAME)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>436.91</b> <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>Cerebro Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>Generalized Arteriosclerosis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>3° A V Block</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>01-18-1970</b> to <b>01-21-1970</b> that (I) (we) last saw the deceased alive on <b>01-21-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>01-21-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>WERNER MEIER M.D.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-24-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 23 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>H. J. Jenkins Sons Co.</b>	
				ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

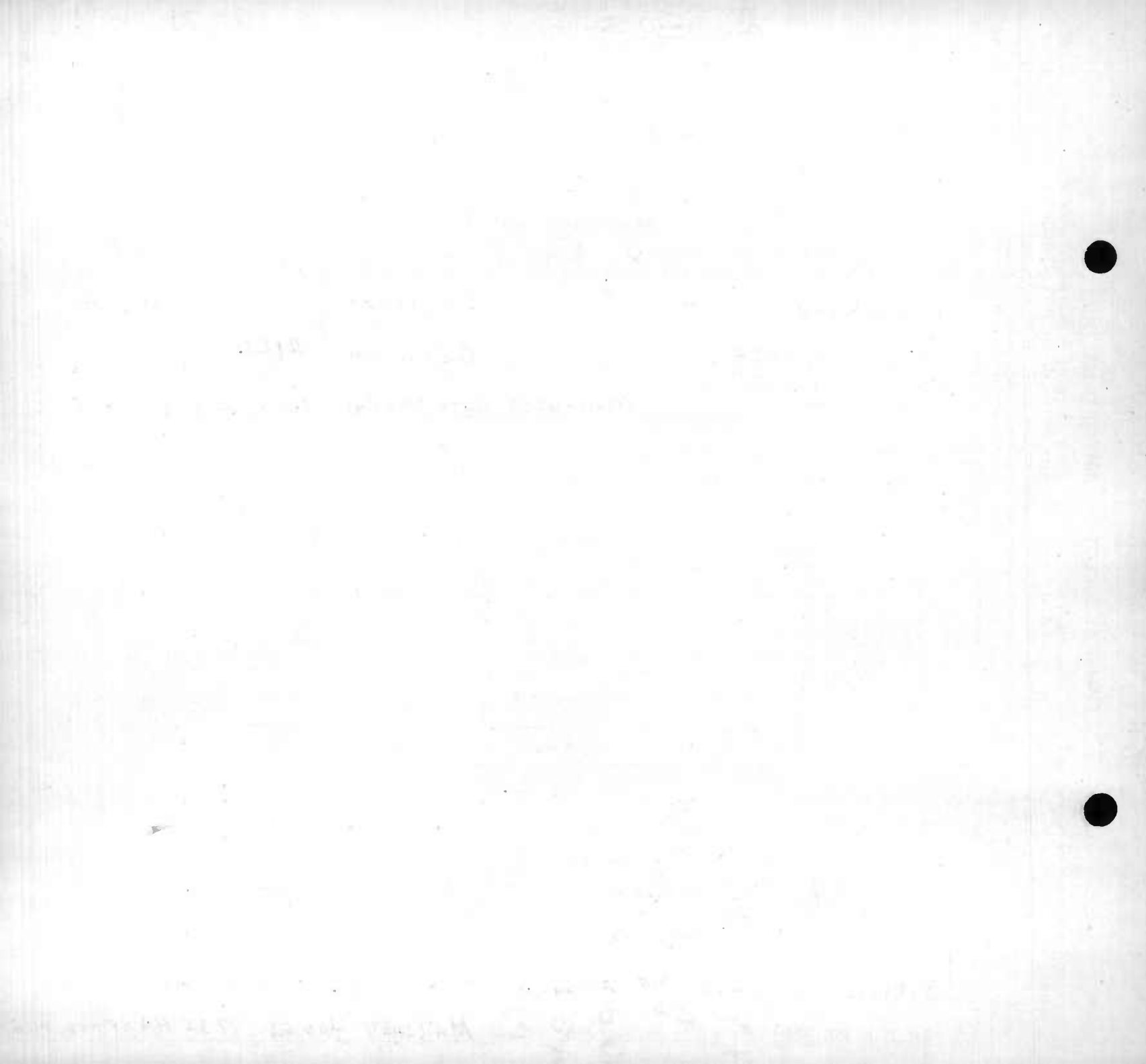
BIRTH NO. 70 00831		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00831	
1. NAME OF DECEASED (Type or Print) <b>JAMES McNEIL</b>			2. DATE AND HOUR OF DEATH <b>1/24/70 at 12 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Swai Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-17</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Swai Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>			6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>11/15/22</b>
13. FATHER'S NAME <b>Charlie McNeil</b>			14. MOTHER'S MAIDEN NAME <b>Mayhelle</b>		9. AGE (In years last birthday) <b>47</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWII</b>			16. SOCIAL SECURITY NO. <b>728-03-8499</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
17. INFORMANT <b>Lucille McNeil</b>			ADDRESS <b>2721 Spaulding Ave</b>		
18. <b>403 X I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Convulsions - Pulmonary Oedema</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Chronic Malignant B/P + Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1/22/70</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) <b>Chronic Hypertension</b> <b>Eyes</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> 19 <b>70</b> to <b>1/24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/24 12 AM</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P.B. Donovan</b>			23B. DATE SIGNED <b>1/24/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>P.B. DONOVAN</b>			23D. ADDRESS <b>Swai Hospital Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat Cem</b>	
24D. LOCATION <b>Balto, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Earl Gilmore</b>		24H. ADDRESS <b>1827 W. North Ave</b>		24I. DATE <b>1/24/70</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
70 00832		REG. NO. 70 00832	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Fuller, Susan BOOZE BYRD		2. DATE AND HOUR OF DEATH 8835PM 21 JAN 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hosp, Baltimore, Md		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1201 14 Ellwood Ave			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/00
9. AGE (In years last birthday) 69		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH BOOZE		14. MOTHER'S MAIDEN NAME GEORGIA HILL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-18-4255	
17. INFORMANT RUTH MYRPHY		ADDRESS 1201 ELLWOOD AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Vremia, Resp Distress		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cervical Ca Metastatic to LIVER 3 yrs	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 3/17/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIR. DISTRESS	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 5 1970 to JAN 21 1970, that (I) (we) last saw the deceased alive on JAN 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Rosenstein		23B. DATE SIGNED 21 JAN 70	
23C. PHYSICIAN'S NAME (Type) Neil B Rosenstein MD		23D. ADDRESS Johns Hopkins Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-70	
24C. NAME OF CEMETERY or CREMATORY MT. AUBURN CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR R. E. Taylor, MD	
25C. FUNERAL DIRECTOR MARSHALL JONES		ADDRESS 1735 HARTFORD AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-340 70 00833 BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH REG. NO. 70 00833

BIRTH NO. 1. NAME OF DECEASED (Type or Print) STEELE, ANNIE 2. DATE AND HOUR OF DEATH 1/24/70 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 A. STATE Maryland B. COUNTY 1509  
 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐  
 E. STREET AND NUMBER 4002 Carlisle Ave. 21216 007

5. SEX Female 6. RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 6-30-85 9. AGE (in years last birthday) 84 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andy Watson 14. MOTHER'S MAIDEN NAME Amanda

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 214-56-6007 17. INFORMANT ADDRESS BCH-Records Baltimore, Maryland 21224

18. 180 X I CAUSE OF DEATH LOWER GI BLEED DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DIVERTICULOSIS OLD CA OF CERVIX (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE C.V.D. (C) DIGITALIS TOXICITY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 20 yr. 3 wk.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/13 1970 to 1/24 1970 that (I) (we) last saw the deceased alive on 1/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Marc F. Colmer, MD 23B. DATE SIGNED 1/24/70

23C. PHYSICIAN'S NAME (Type) Marc F. Colmer, MD 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 1/28/70 24C. NAME OF CEMETERY OR CREMATORY FARMER PLOT 24D. LOCATION (City, town, or county) (State) Just Mill S.C.

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR 25D. ADDRESS

JAN 26 1970





# FUNERAL DIRECTOR: IMPORTANT

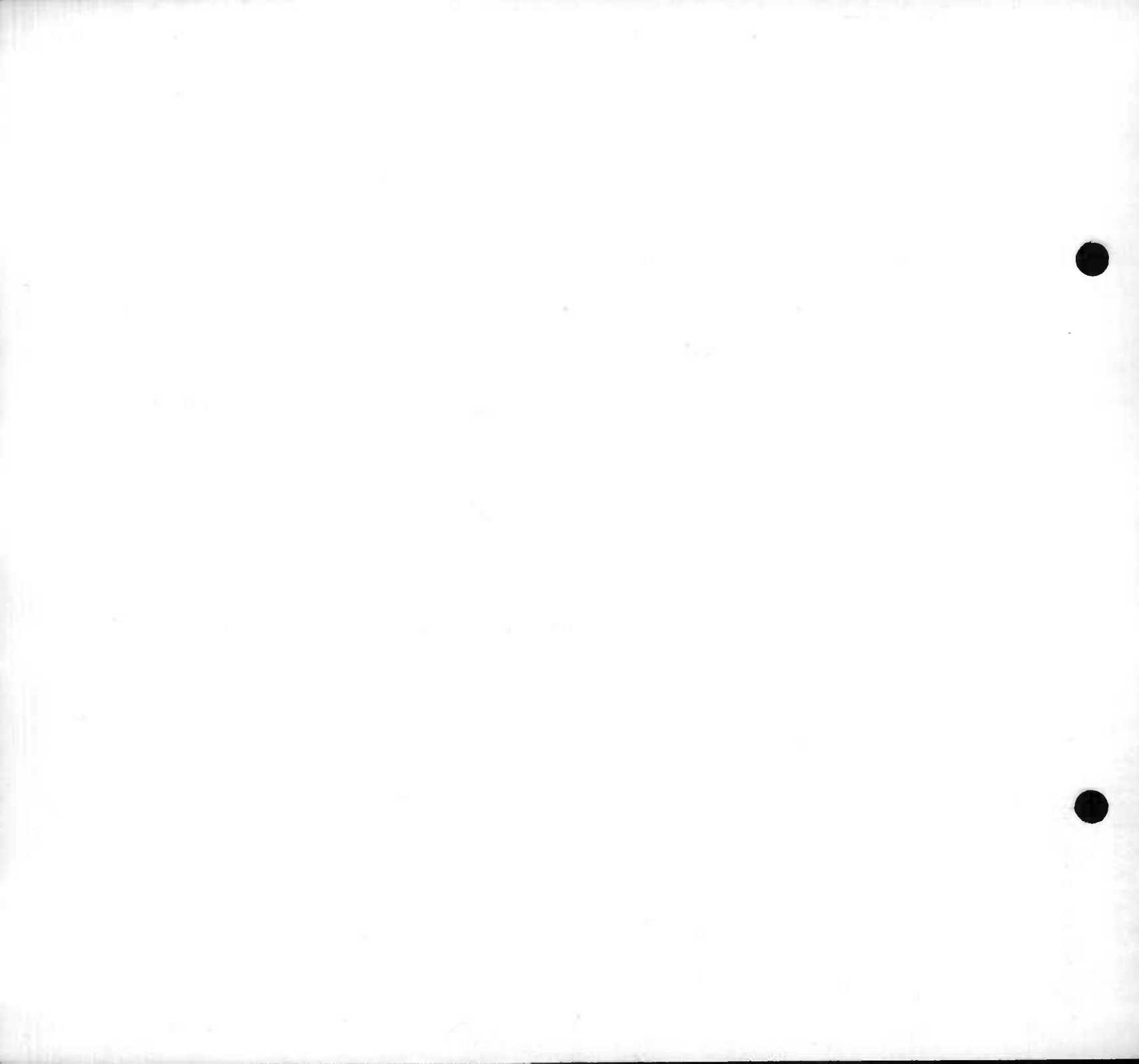
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200 70 00834		BALTIMORE CITY HEALTH DEPARTMENT		70 00834	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSA L. CHASE		1-24-70 7.30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE MD		B. COUNTY A.A.C. 52-00	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BAY SEVERN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Box 232 QUEENSTOWN RD			
5. SEX F	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 14 1902	9. AGE (in years lost birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse man
		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) A.C. MD	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARDSON		14. MOTHER'S MAIDEN NAME MANTNA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Edgar R. Chase	
				ADDRESS SEVERN MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157.0 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: generalized metastasis cancer of head of pancreas (B) Cancer of head of pancreas DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-31-1969 to 1-24-1970 that (I) (we) last saw the deceased alive on JAN 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sutin Srisumrid M.D.		23B. DATE SIGNED Jan 24, 1970		23C. PHYSICIAN'S NAME (Type) SUTIN SRISUMRID M.D.	
23D. ADDRESS Mercy Hospital 301 ST. PAUL PL, BALTO, MD 21202		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/26/70		24C. NAME OF CEMETERY OR CREMATORY Mt A. Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT. JAN 26 1970		24H. NAME OF REGISTRAR Rosa L. Chase		24I. FUNERAL DIRECTOR Rosa L. Chase	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

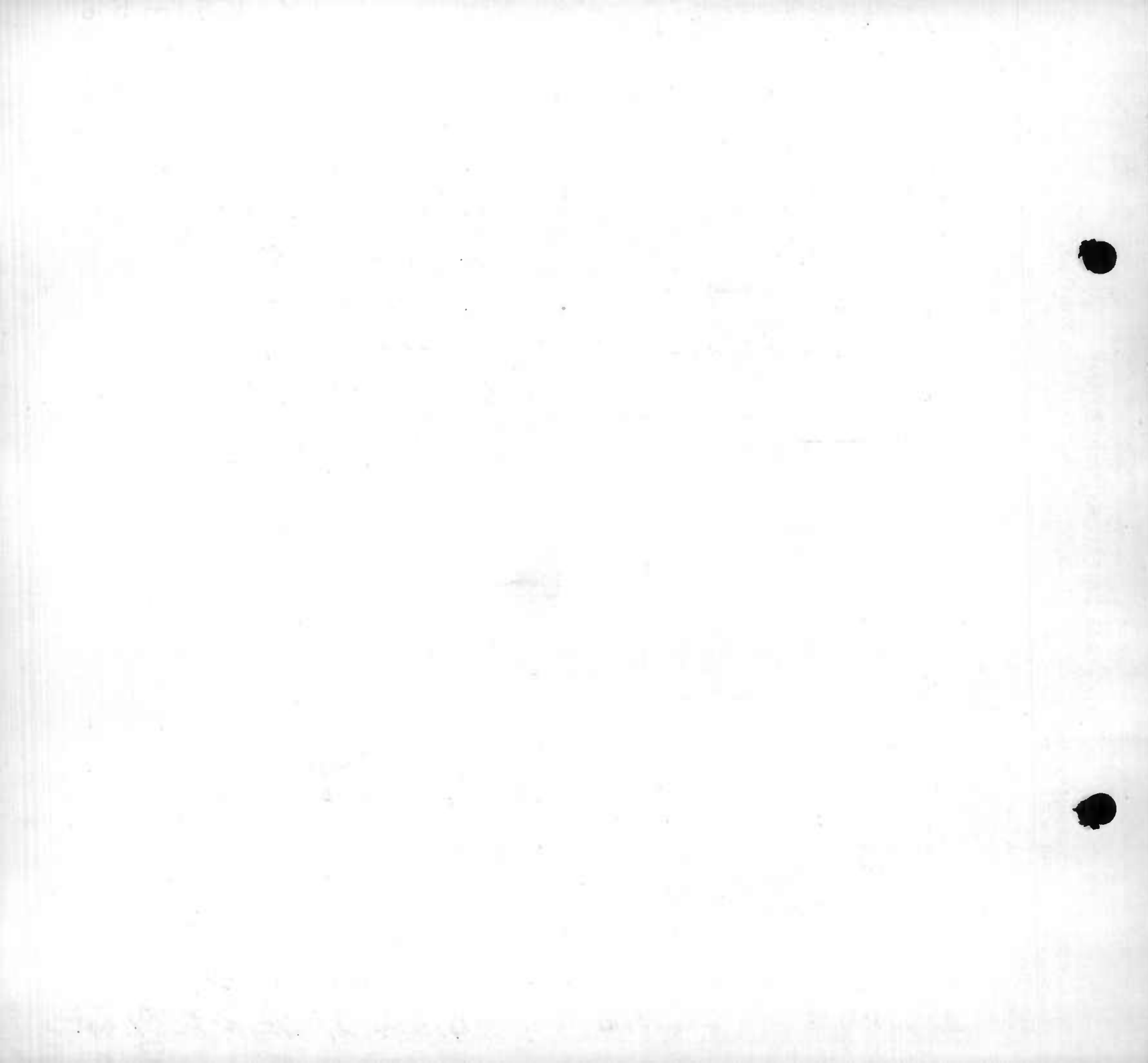
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00835</u>	
D-635 70 00835		70 00835	
BIRTH NO. <u>1</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LUCINDA DIKTON</u>		2. DATE AND HOUR OF DEATH <u>JAN 25-1970 4:10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSP</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2506</u>	
5. SEX <u>FEMALE</u> 6. RACE <u>COLORED</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-16-1891</u> 9. AGE (in years last birthday) <u>79</u>		E. STREET AND NUMBER <u>1526 CHESPENICE AVE</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>WHITFIELD BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>L. BROOKS.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JAMES DINTON 1526 CHESPENICE AVE</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>2 to Bacterial Endocarditis</u> <u>2 to Enterobacter cloacae bacteremia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Peptic ulcer and malena + ? Cancer Cervix</u>			
19A. DATE OF OPERATION <u>1-25-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>2:30 p 11-25-1969</u> to <u>4:10 am 1-25-1970</u> that (H) (we) last saw the deceased alive on <u>4:10 am 1-25-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u> MD		23B. DATE SIGNED <u>1-25-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>HENRY CHEN MD</u>		23D. ADDRESS <u>3001 S-HANOVER ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/29/70</u>	
24C. NAME of CEMETERY or CREMATORY <u>WAT CATHARY</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD 21225</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

177-640 70 00836		BALTIMORE CITY HEALTH DEPARTMENT		70 00836	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MUREL, WOODROW		2. DATE AND HOUR OF DEATH 1. 24. 70 2. 55 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 1603		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1621 HARLEM AVE.	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 7-1912	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY OIL Co.		11. BIRTHPLACE (State or foreign country) NORFOLK - VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Murel		14. MOTHER'S MAIDEN NAME ADA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Edward Murel 1621 Harlemon Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia R.L.L.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-20-70 to 1.24.70	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1. 22. 1970 to 1 - 24. 1970, that (1) (we) last saw the deceased alive on 1. 24. 1970 and that in (my) (aye) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. G. Nanes MD		23B. DATE SIGNED 1. 24. 70		23C. PHYSICIAN'S NAME (Type) P. G. Nanes MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE RECD. BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR John E. Taylor	
25C. FUNERAL DIRECTOR Margaret A. Lyons		25D. ADDRESS 636 N. 9th St.			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00837

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM T. BEALE

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

1

20

70

5:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1600 Milliman St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

January 20,

1970

5:45 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS

YES ☐NO ☐

9. DATE OF BIRTH

July 1, 1901

10. AGE (In years  
last birthday)

68-69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1600 Milliman St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

William O. Beale

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Janitor

14B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

15. MOTHER'S MAIDEN NAME

Gertrude Virginia Gibson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Gertrude V. Beale

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Sepsis  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/25/70

24C. NAME OF CEMETERY or CREMATORY

Hollywood

24D. LOCATION

(City, town, or county)

(State)

Remington, Virginia

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1970

Moser Funeral Home, Warrenton, Va.

THE UNIVERSITY OF CHICAGO  
LIBRARY

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1-212 70 00838 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 70 00838

BIRTH NO. 69-23360

1. NAME OF DECEASED (Type or Print) <b>PAULA JACOBS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTO. CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD January 20, 1970		Month	Day	Year	Hour 11:40 A.M.
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 18, 1969		10. AGE (In years last birthday) 1		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Linda Kobuck		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. None		18. INFORMANT William Jacobs		ADDRESS 7862 Rockbourn Road.		19. CAUSE OF DEATH Sudden death in infancy	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/21/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR R. N. Kornblum		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Dundalk, Md.			

VS 151-REV. 7/1/68

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

REPORT OF THE  
SALT LAKE CITY WATER RESOURCES DIVISION

ON THE  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

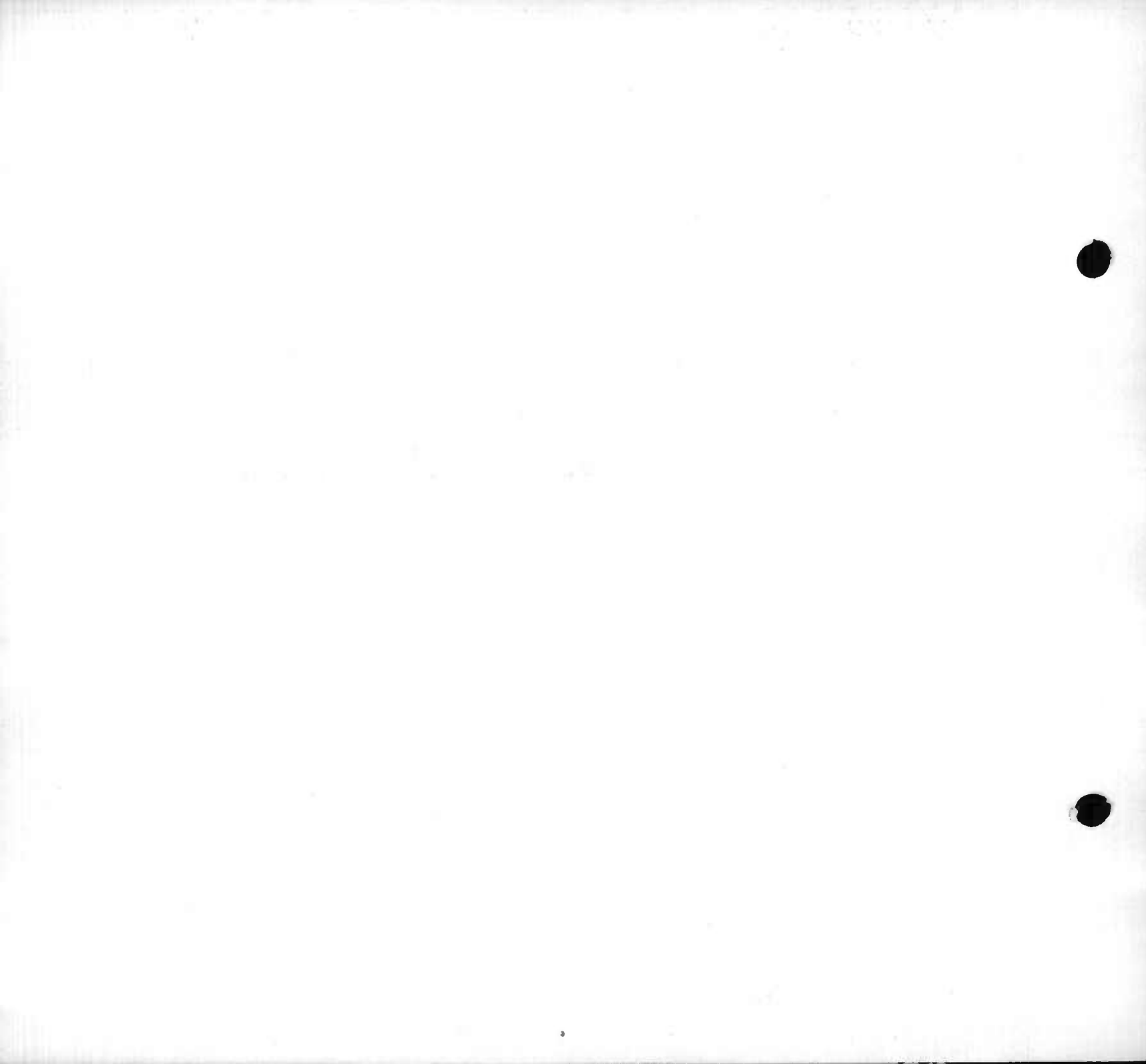
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 00839
BIRTH NO. <span style="float: right;">V-340 70 00839</span>		1. NAME OF DECEASED (Type or Print) <b>Lola L. Vadaia</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>4:40 pm 1/19/70</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2788</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W</b>		E. STREET AND NUMBER <b>3803 Hayward Ave</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/15/102</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>67</b>
13. FATHER'S NAME <b>Robert D Sadler</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
14. MOTHER'S MAIDEN NAME <b>Sarah Fairbank</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>217-26-4671</b>		17. INFORMANT <b>FRANK VADALIA</b>		
18. <b>519.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Chronic obstructive lung disease</b>		ADDRESS <b>3404 NORTHWAY DR</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0. year.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from <b>1/12/1970</b> to <b>1/19/1970</b>		21F. HOW DID INJURY OCCUR?		
that (I) (we) lost saw the deceased alive on <b>1/19/1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <b>1/19/70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Union Memorial Hospital</b>		23D. ADDRESS <b>Union Memorial Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/23/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>UDICH FUNERAL HOME - 4210 BELMONT RD</b>

154-25-3

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

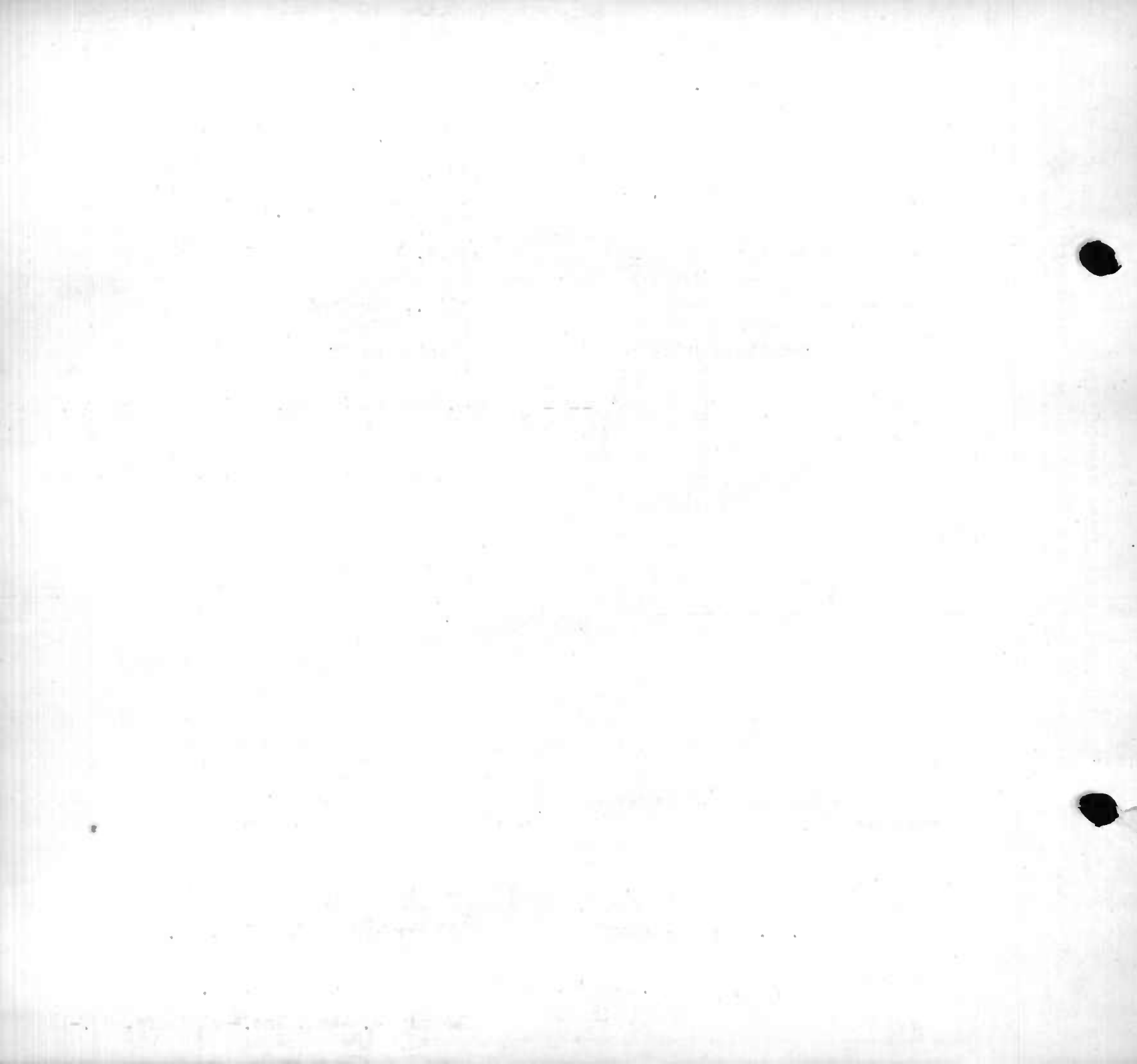
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00840</u>	
BIRTH NO. <u>H-120</u>		70 00840			
1. NAME OF DECEASED (Type or Print) <u>WALTER HEVESSY</u>			2. DATE AND HOUR OF DEATH <u>3:55 1/18/70</u> <u>A</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNIVERSITY HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2901 DUNMORE RD.</u>		
5. SEX <u>M</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/09</u>	9. AGE (in years last birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>	
13. FATHER'S NAME <u>MATTHIAS HEVESSY DEC.</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA NOVAK DEC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>119-18-1470</u>		17. INFORMANT <u>CHART</u> ADDRESS <u>DEC.</u>	
18. <u>569.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>GI Bleeding</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MALNUTRITION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>RENAL FAILURE</u> (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____ 19A. DATE OF OPERATION <u>1/17/70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GI Bleeding</u>		
20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____ 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> _____ 21F. HOW DID INJURY OCCUR? _____ 22. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> 19 <u>70</u> to <u>1/18</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. _____ 23A. SIGNATURE <u>Marvin E. Zipes, M.D.</u>			23B. DATE SIGNED <u>1/18/70</u>		
23C. PHYSICIAN'S NAME (Type) _____ 23D. ADDRESS _____ DEGREE _____			23E. ADDRESS _____ DEGREE _____		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/21/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	
24D. LOCATION <u>BALTIMORE MD.</u>		24E. NAME OF REGISTRAR <u>COLEMAN FUNERAL HOME DUNDALK MD.</u>		24F. FUNERAL DIRECTOR <u>COLEMAN FUNERAL HOME DUNDALK MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>COLEMAN FUNERAL HOME DUNDALK MD.</u>		25C. FUNERAL DIRECTOR <u>COLEMAN FUNERAL HOME DUNDALK MD.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">70 00841</span>					REG. NO. <span style="float: right;">70 00841</span>				
1. NAME OF DECEASED (Type or Print) <b>JULIA A. DENNER</b>					2. DATE AND HOUR OF DEATH <b>Jan. 21, 1970</b> <span style="float: right;">6 A. M.</span>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <span style="float: right;">2641</span>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4303 Willshire Ave.</b>					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <b>4303 Willshire Ave.</b>				
5. SEX <b>female</b>	6. RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 21, 1888</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Balto., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Franklin Hedrick</b>					14. MOTHER'S MAIDEN NAME <b>Annie Mae Brown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-46-2066</b>		17. INFORMANT ADDRESS <b>Mrs. Dora A. Freyer, 4303 Willshire Ave, Balto</b>			
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral atherosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>3 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>Jan 21 1970</b> , that (I) <del>was</del> last saw the deceased alive on <b>December 8 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did not</del> view the body after death.									
23A. SIGNATURE <b>Donald Jandorf</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>1-21-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. R. Donald Jandorf</b>					23D. ADDRESS <b>7403 Harford Road, Balto, Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/24/70</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Mary's, Hampden</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Valerie</b>			25C. FUNERAL DIRECTOR <b>Donald J. Ruck, Inc.</b>			ADDRESS <b>Baltimore, Md.</b>	

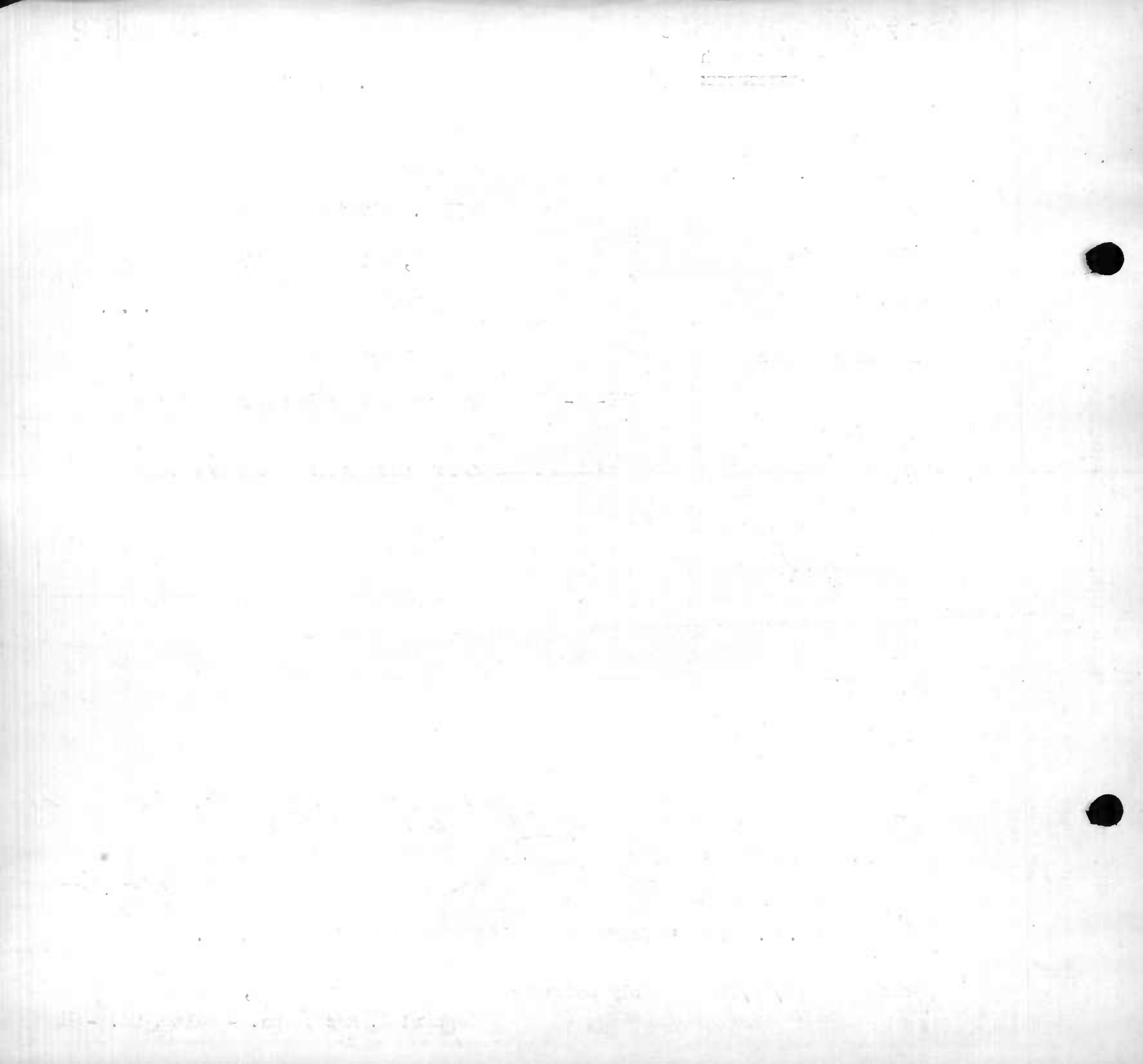




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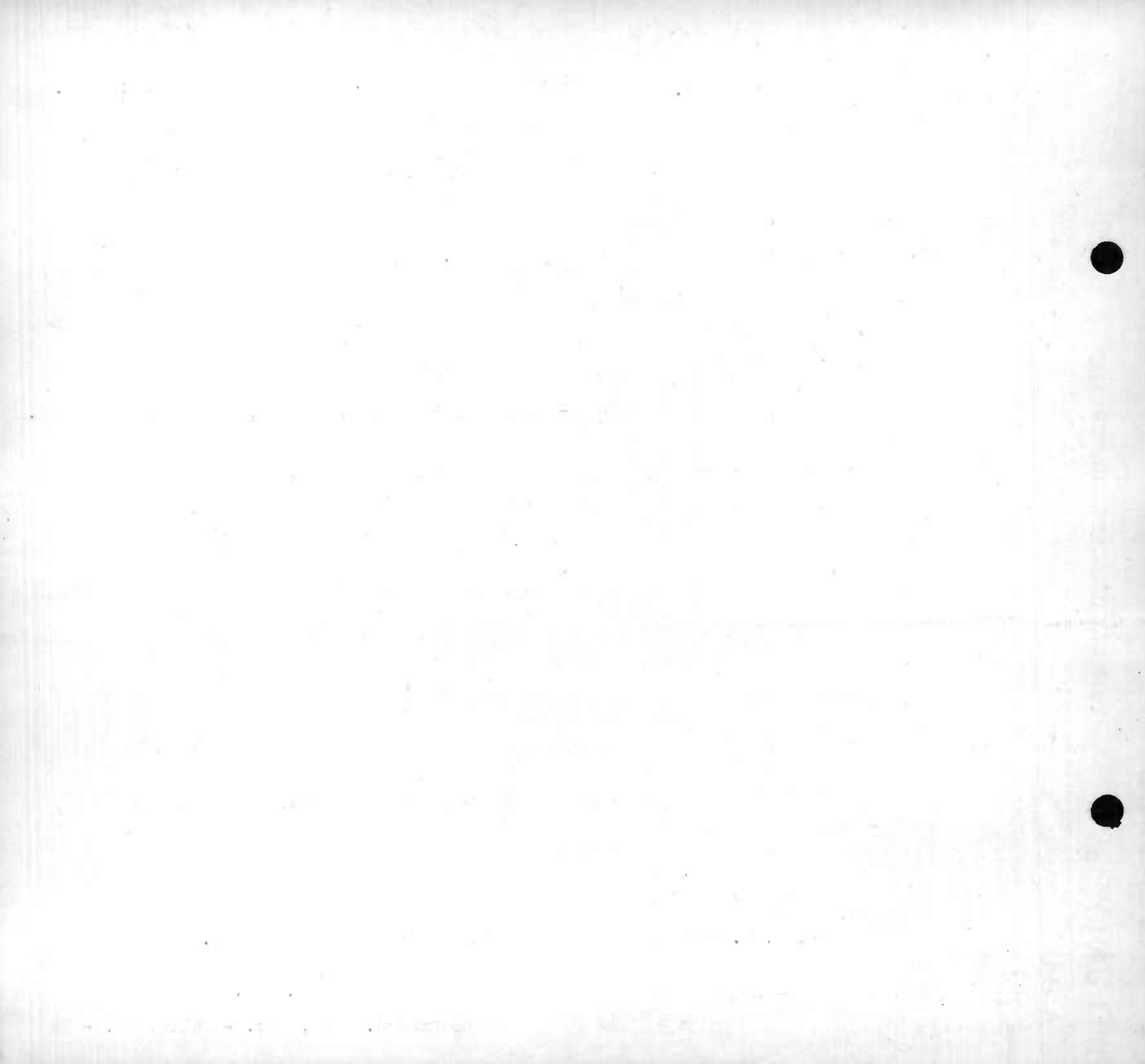
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00842</u>	
<div style="display: flex; justify-content: space-between;"> <span><u>S-415</u> <u>70 00842</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED <u>Elisabeth</u>		2. DATE AND HOUR OF DEATH	
(Type or Print)		<del>Elisabeth</del> <u>L. SCHLEUPNER</u>		<u>Jan. 20, 1970</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>44</u> <u>UNION MEMORIAL HOSPITAL</u>				A. STATE <u>Maryland</u>	
				B. COUNTY <u>2748</u>	
				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1233 E. Belvedere Avenue</u>	
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Sept 16, 1892</u>	9. AGE (In years last birthday) <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alphonsus H Glos</u>		14. MOTHER'S MAIDEN NAME <u>Mary Albert</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-6427B</u>		17. INFORMANT <u>Mr Charles J Schleupner</u>	
				ADDRESS <u>Same</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Acute Myocardial Infarction</u>	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 13 1964</u> to <u>11/28 1969</u> , that (I) (we) last saw the deceased alive on <u>11/28 1969</u> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. W. Meredith Smith M.D.</u>				23B. DATE SIGNED <u>1/24/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. W. Meredith Smith</u>				23D. ADDRESS <u>6305 The Alameda, Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Miller</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md. - 14</u>	



# FUNERAL DIRECTOR: IMPORTANT

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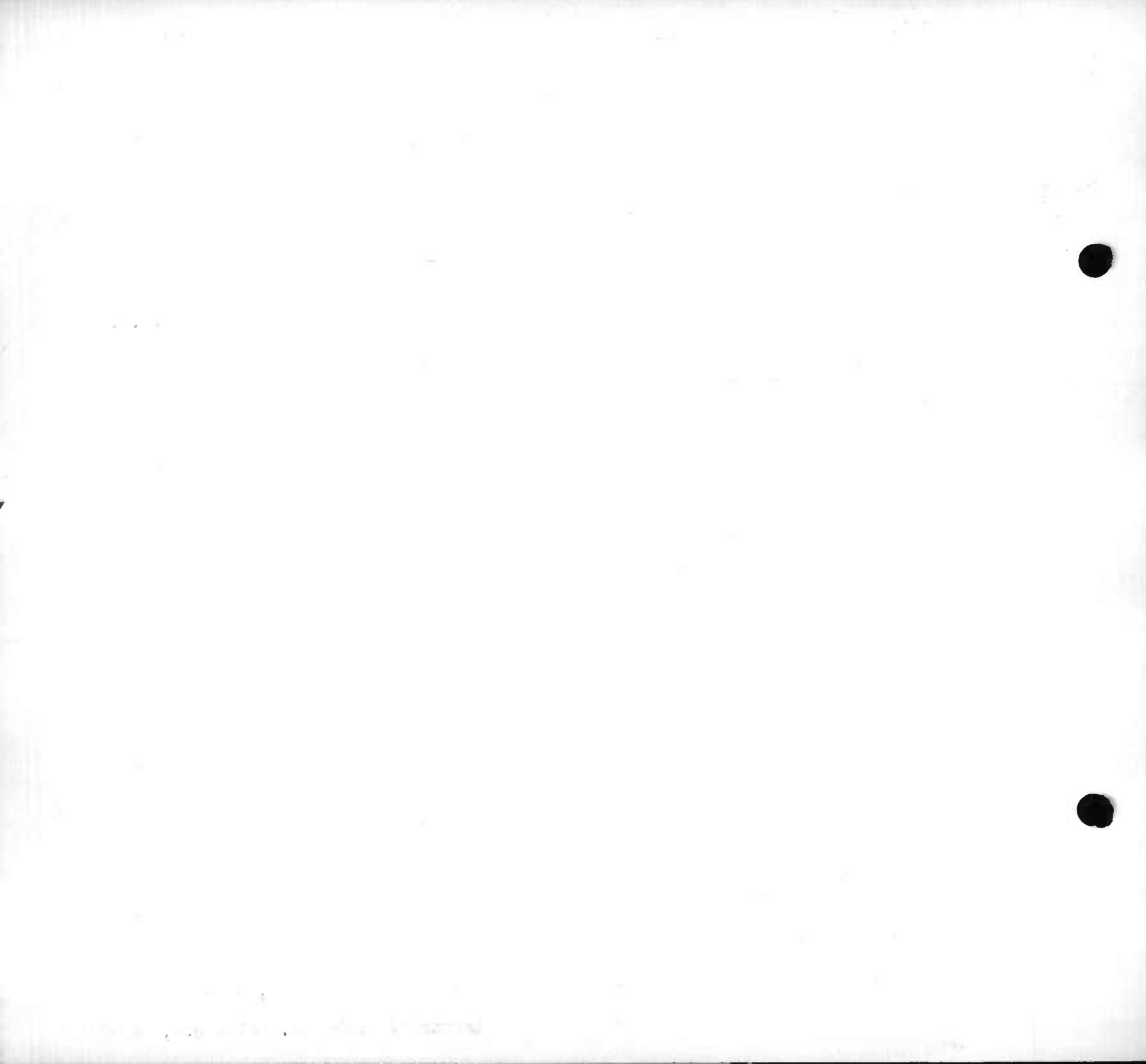
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00843</span>	
BIRTH NO. <span style="font-size: 2em;">R-143</span>		70 00843		CERTIFICATE OF DEATH <span style="float: right;">X</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LOUIS J. RIEBOLD</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Jan. 20, 1970</span> <span style="float: right;">12:20 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">BALTIMORE CITY HOSPITALS</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Balto.</span>		
5. SEX <span style="font-size: 1.2em;">male</span>			6. RACE <span style="font-size: 1.2em;">caucasian</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Print Shop</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Glazier</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Louis G. Riebold</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Zimmerman</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-07-2645</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs Marie T. Price, 8053 Wynbrook Rd.</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Coronary Thrombosis</span> (B) <span style="font-size: 1.5em;">Arteriosclerotic Cardiovascular Disease</span> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/16</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">Jan 20</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">Jan 19</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">1/21/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. L. B. Stevens</span>				23D. ADDRESS <span style="font-size: 1.2em;">3400 Erdman Ave, Balto, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">1-24-70</span>		<span style="font-size: 1.2em;">Most Holy Redeemer</span>	
24D. LOCATION (City, town, or county)		24E. STATE			
<span style="font-size: 1.2em;">Balto. Md.</span>		<span style="font-size: 1.2em;">Md.</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.2em;">JAN 26 1970</span>		<span style="font-size: 1.2em;">Robert E. [Signature]</span>		<span style="font-size: 1.2em;">Leonard J. Rack, Inc. - Balto, Md. - 14</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

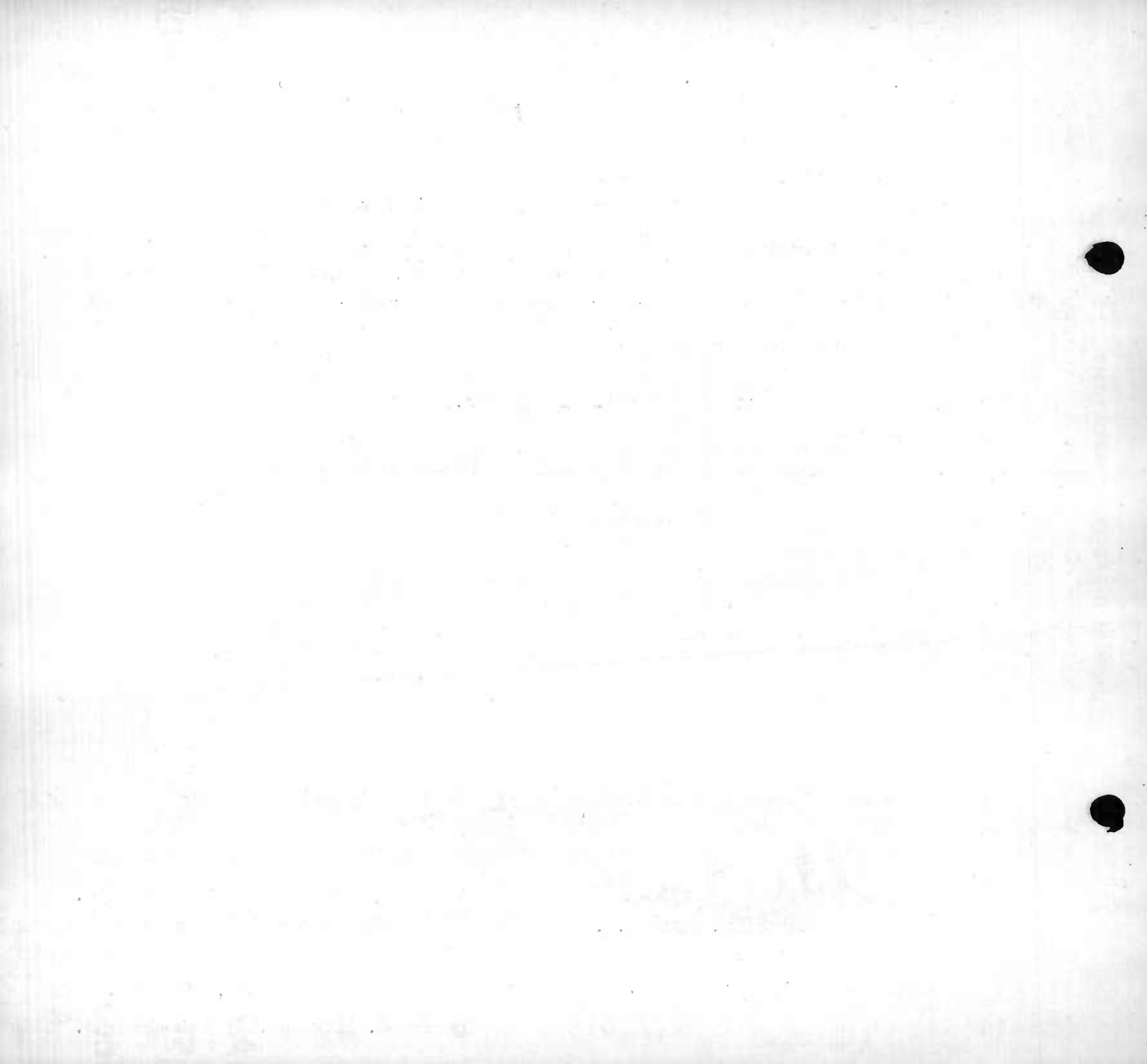
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00844	
CERTIFICATE OF DEATH					
BIRTH NO. <u>A-615</u>		70 00844			
1. NAME OF DECEASED (Type or Print) <u>ROSE ARABIAN</u>			2. DATE AND HOUR OF DEATH <u>Jan 21 1970 10 45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3311 RICHMOND AVENUE</u>		<u>21213</u>
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1929</u>	9. AGE (In years last birthday) <u>40</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Nishan Kashadourian</u>			14. MOTHER'S MAIDEN NAME <u>Queen Berberian</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr Adam Arabian</u> <u>Same</u>
18. <u>206.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Monocytic Leukemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6m</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 9 1970</u> to <u>Jan 21 1970</u> that (I) (we) last saw the deceased alive on <u>Jan 21 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C Delgado</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>CESAR DELGADO</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>123/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>Jan 26 1970</u>		25B. NAME of REGISTRAR <u>Leonard J. Rack Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Maryland</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																								
70 00845					CERTIFICATE OF DEATH					REG. NO. 70 00845														
BIRTH NO. <u>L-140</u>																								
1. NAME OF DECEASED (Type or Print) <u>Carl L. Lavell</u>					2. DATE AND HOUR OF DEATH <u>January 22, 1970</u>					2 A. M.														
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2706</u>														
										C. CITY OR TOWN <u>Baltimore</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
										E. STREET AND NUMBER <u>2606 Gibbons Avenue</u>														
5. SEX <u>Male</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/1912</u>		9. AGE (In years last birthday) <u>57</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>					11. BIRTHPLACE (State or foreign country) <u>Virginia</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Christian Lavell</u>										14. MOTHER'S MAIDEN NAME <u>Alice Burnett</u>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>					16. SOCIAL SECURITY NO. <u>230-10-5668</u>					17. INFORMANT <u>Mrs. Ruby Lavell</u>					ADDRESS <u>Same</u>									
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										CAUSE OF DEATH <u>Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <u>12-11-1967</u> to <u>1-11-1970</u> that (I) (we) last saw the deceased alive on <u>1-11-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <u>Sebastian Russo M.D.</u>										23B. DATE SIGNED <u>1/22/70.</u>														
23C. PHYSICIAN'S NAME (Type) <u>Sebastian Russo M.D.</u>										23D. ADDRESS <u>5017 Harford Road Baltimore Maryland</u>														
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>1/26/70</u>					24C. NAME of CEMETERY or CREMATORY <u>Mt. Pleasant Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia.</u>									
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR <u>770000</u>					25C. FUNERAL DIRECTOR <u>Leonard J. Back Inc.</u>					ADDRESS <u>5305 Harford Rd. 21214</u>									





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>70 00846</u>	
<b>BIRTH NO.</b> <u>6-233 70 00846</u>				<b>CERTIFICATE OF DEATH</b>	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Geisendaffer, Robert C.</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>1/23/70</u> <u>4:40 A.M.</u>	
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> <u>48</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>806</u> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>Baltimore</u> <b>D. STREET ADDRESS</b> (If rural, give location) <u>1714 Lannale St.</u>	
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>02-06-95</u>	<b>9. AGE</b> (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Isaac Benesch (Chauffeur)</u>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
<b>13. FATHER'S NAME</b> <u>Charles Geisendaffer</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Dudley</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>215-05-5676</u>		<b>17. INFORMANT</b> <u>Mrs. Mary F. Geisendaffer</u>
			<b>ADDRESS</b> <u>(Same)</u>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) DUE TO <u>Myocardial infarction</u> (B) DUE TO <u>Coronary Artery Disease</u> (C) <u>Arterio sclerosis</u> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 years.</u>		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>NONE</u>		
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>70</u> to <u>1/23</u> 19 <u>70</u>, that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Stuart V. Grandis</u>				<b>23B. DATE SIGNED</b> <u>1/23/70</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Stuart V. Grandis</u>				<b>23D. ADDRESS</b> <u>Maryland General Hospital</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1/27/70.</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Parkwood Cemetery</u>	
		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 26 1970</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Leonard J. Buck, Inc. Balto. Md. 21214</u>	

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# FUNERAL DIRECTOR: IMPORTANT

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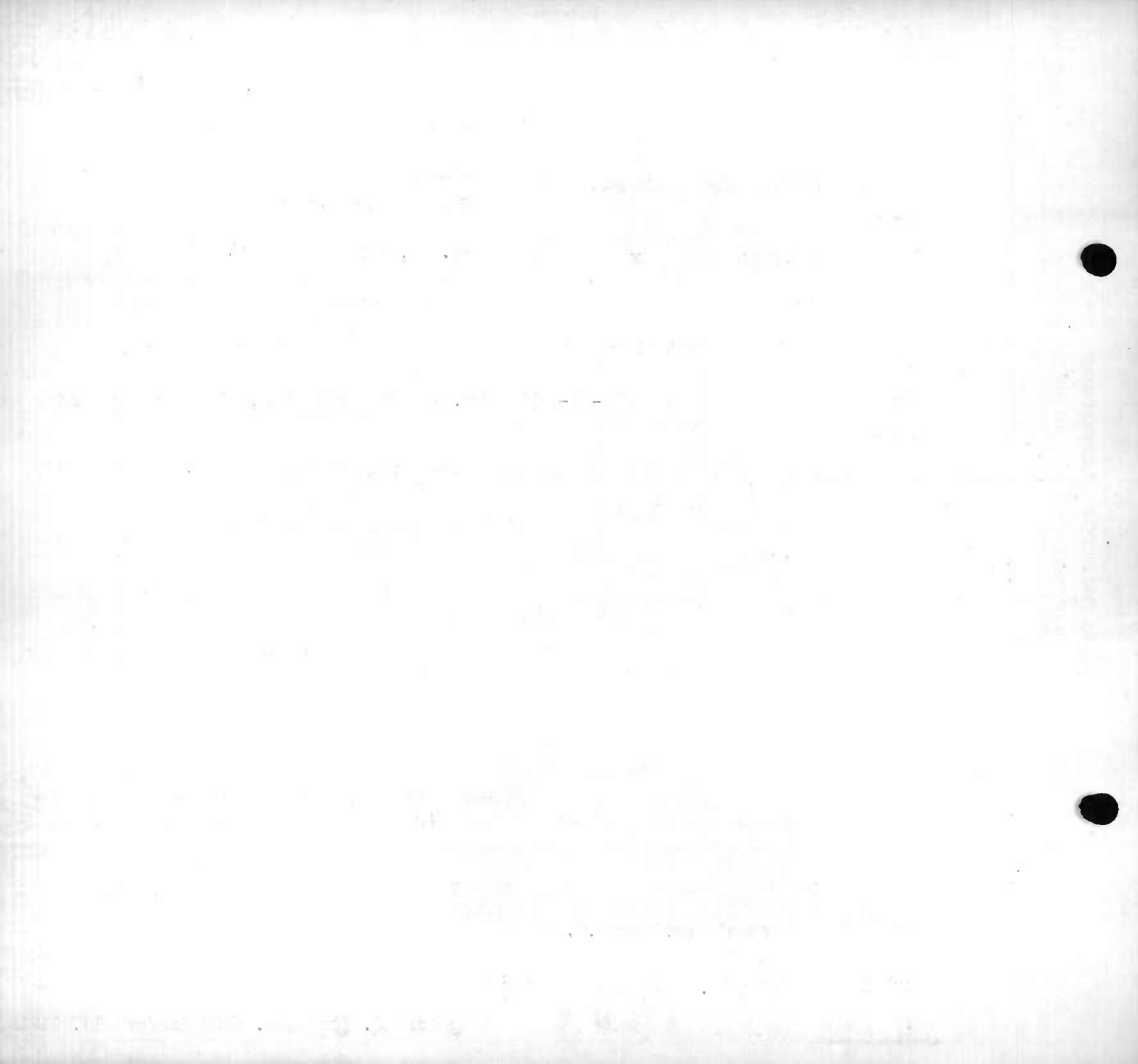
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00847</u>	
P-632 70 00847		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUIS JOHN PERTESESS		January 22, 1970 7 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  512 N. Franklintown Rd.			A. STATE Maryland B. COUNTY 2002		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
512 N. Franklintown Rd.			E. STREET AND NUMBER 512 N. Franklintown Rd.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1902	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-3441		17. INFORMANT Mr. John Pertesess, 112 E. 25th. St. Balto. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/22/70		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 1960 to 1/22 1970, that (I) (we) last saw the deceased alive on 1/12 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Thomas Roach				23B. DATE SIGNED 1/22/70	
23C. PHYSICIAN'S NAME (Type) Dr. Thomas Roach				23D. ADDRESS 5550 Baltimore Natl. Pike, Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70		24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery	
				24D. LOCATION (City, town, or county) (State) Westminster, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. Salyer		25C. FUNERAL DIRECTOR Leonard J. Huck Inc., Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

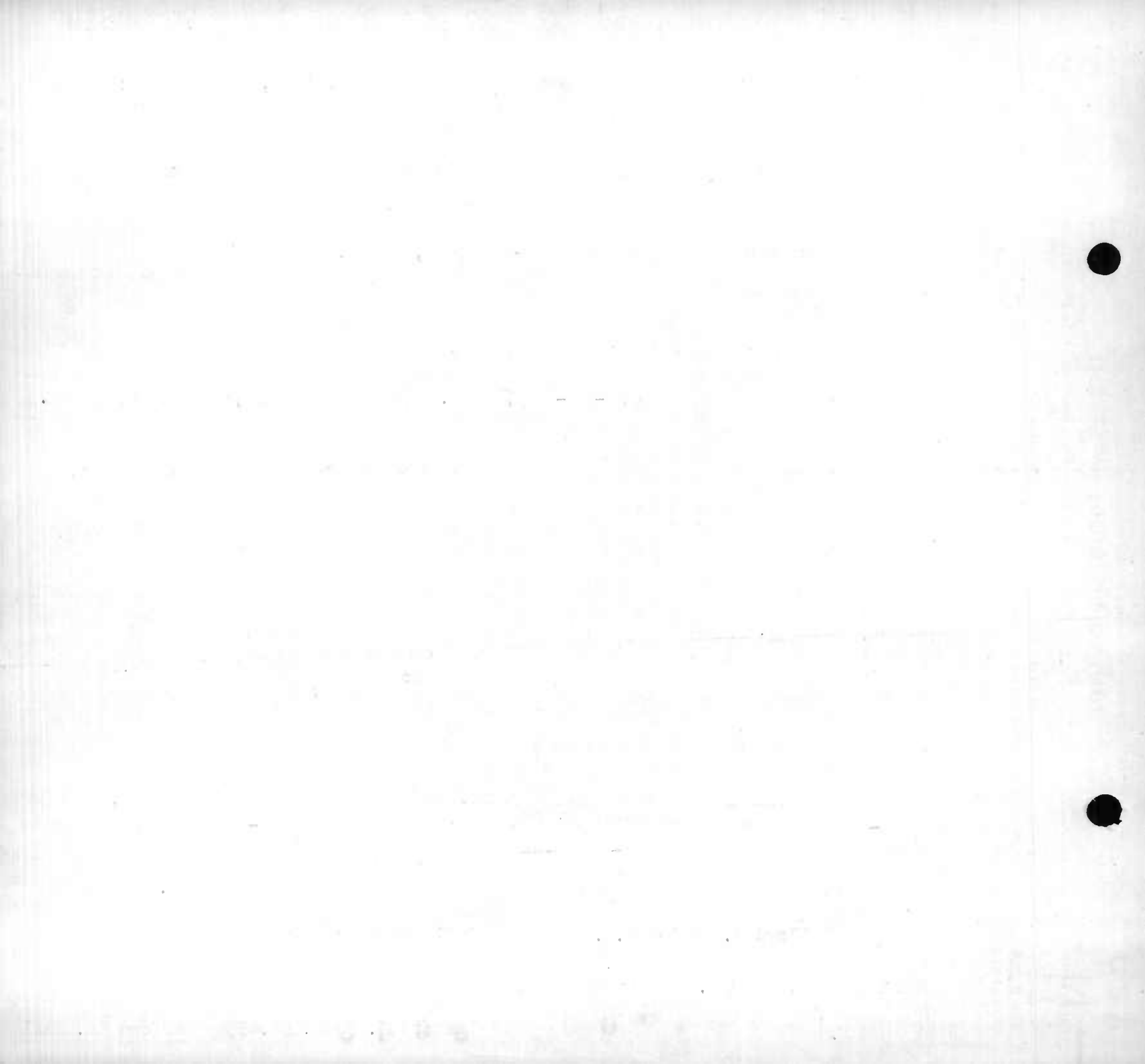
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					REG. NO. 70 00848						
BIRTH NO. 3-452 70 00848					2. DATE AND HOUR OF DEATH January 22, 1970 7:30 P.M.						
1. NAME OF DECEASED (Type or Print) Ernest Paul Schilling					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 House in the Pines Belvedere					A. STATE Maryland		B. COUNTY Baltimore				
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Male 6. RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Dec. 21, 1875		9. AGE (In years last birthday) 94		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Schilling					14. MOTHER'S MAIDEN NAME Emily ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-07-2071		17. INFORMANT ADDRESS Mr. William Schilling, 8135 Pleasant Plains Rd				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure					3 weeks	
					(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic vascular disease					Progressive for years	
					(C) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus					years	
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 21, 1968 to 1/22 1970, that (I) (we) last saw the deceased alive on 1/21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Samuel Morrison					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/22/70			
23C. PHYSICIAN'S NAME (Type) Samuel Morrison M.D.					23D. ADDRESS 11 E. Chase St 21202						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/70.		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Leonard J. Buck Inc.			ADDRESS 5305 Harford Rd. 21214			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00849	
<div>C-615 70 00849</div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		(Type or Print) Estella Carbon		January 22, 1970 7:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital			A. STATE Maryland B. COUNTY 1201		
5. SEX Female			6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 4, 1892.
9. AGE (In years lost birthday) 77			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
			Homemaker		Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joshua Cole			14. MOTHER'S MAIDEN NAME Betty Baker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-26-8957		17. INFORMANT ADDRESS Mrs. Edna Dougherty, 6300 Liberty Rd.
15. No					
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Coronary artery disease 3 yrs. DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease 10 yrs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 26 19 68 to January 22, 1970, that (I) (we) last saw the deceased alive on January 20, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor				23B. DATE SIGNED Jan. 23, 1970	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor M.D.				23D. ADDRESS 3902 Greermount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard A. Buck Inc. 5305 Harford Rd. 21214	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-552		70 00850		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00850	
BIRTH NO. Martin J Jennings		1. NAME OF DECEASED (Type or Print) MARTIN J. JENNINGS				2. DATE AND HOUR OF DEATH 1/23/70 1:20 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hosp. Baltimore.				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BAY/10		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/31/95		9. AGE (in years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Weigher American Refinery				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Jennings				14. MOTHER'S MAIDEN NAME Catherine ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1,		16. SOCIAL SECURITY NO. 217-16-5122		17. INFORMANT Mrs Cora E Jennings		ADDRESS Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/23/70 19 to 1/23/70 19 that (I) (we) last saw the deceased alive on 1/23/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. M. V. M. D.				23B. DATE SIGNED 1/23/70		23C. PHYSICIAN'S NAME (Type) DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/70		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. V. M. D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Baltimore, Maryland			

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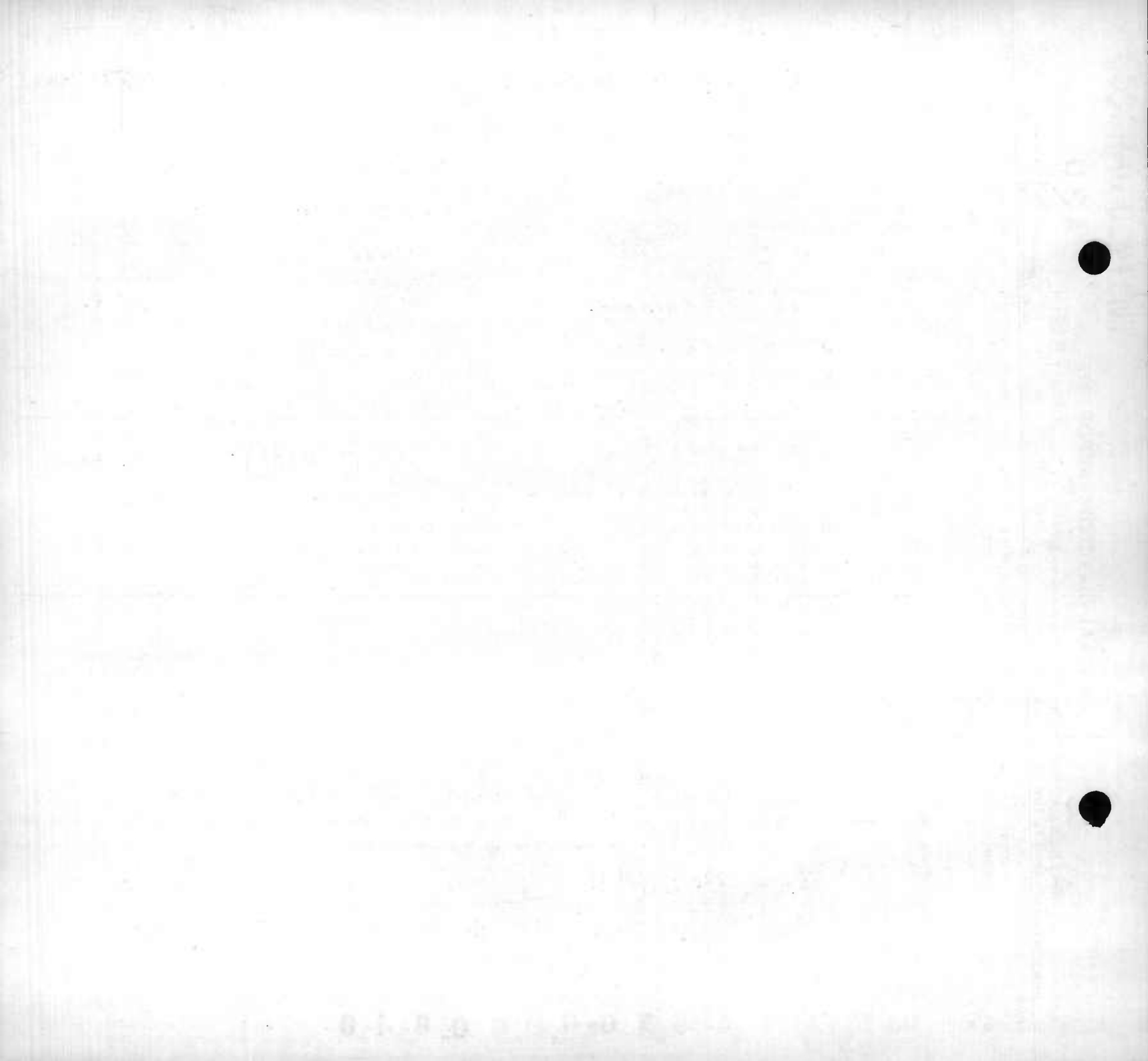
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-125		70 00852		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO. 70 00852	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GIBSON, HELEN ELIZABETH				2. DATE AND HOUR OF DEATH 1/21/70 9:30A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40				C. CITY OR TOWN CATONSVILLE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 216 BLAKENEY RD											
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 5 99	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY HOME				11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME THOMAS STROMBERG				14. MOTHER'S MAIDEN NAME ANNA CLARK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219 14 1484				17. INFORMANT CATON BALTO MD 2122 ADDRESS ST AGNES HOSP RECORDS WILKENS &			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Due to, or as a consequence of: Unrecorded Information				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (X) (this hospital) attended the deceased from 11/15 19 69 to 1/21/ 19 70 that (X) (we) lost saw the deceased alive on 1/21/ 19 70 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE Romualdo P. Dator, MD				23B. DATE SIGNED 1-21-70				23C. PHYSICIAN'S NAME (Type) ROMUALDO DATOR, MD			
23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON BALTO MD 21229				24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-24-70			
24C. NAME of CEMETERY or CREMATORY Cathedral Cemetery				24D. LOCATION Baltimore, Md.				24E. DATE REC'D BY HEALTH DEPT. JAN 26 1970			
24F. NAME OF REGISTRAR Robert E. Taylor, MD				24G. FUNERAL DIRECTOR D. G. 4-2				24H. ADDRESS Catonville, Md.			

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70 00853

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 00853

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>DANIEL BELL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 16, 1970</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 16, 1970 2:25 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>808</b>	
9. DATE OF BIRTH <b>Sept. 10, 1927</b>		10. AGE (in years lost birthday) <b>42</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>John W. Bell</b>		15. MOTHER'S MAIDEN NAME <b>Ada Wise</b>	
18. INFORMANT		ADDRESS	
19. <b>009.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hemorrhagic gastroenteritis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 18, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-21-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Hopkins Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Highland Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert L. Snowden</b>	
25C. FUNERAL DIRECTOR		ADDRESS <b>Rockville, Md.</b>	

NOVEMBER 1917  
THE OCEANOGRAPHIC  
AND NAVAUTIC  
PUBLICATIONS

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New York, N. Y.



P-600

70 00854

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00854

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES V. PARR</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 12 70 1:10 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>905 Hollins St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 12, 1970 1:10 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/2/1900</b>		10. AGE (In years last birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>watchman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>705-10-9612</b>	
15. MOTHER'S MAIDEN NAME <b>unknown</b>		18. INFORMANT <b>Donald Discharge - W. W. II</b>	
19. <b>41 2.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(b) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(c) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12 1 1970</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>YES</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Isidore Mihalekis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): <b>Isidore Mihalekis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: <b>1/13/70</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/23/1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Bethel National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>Jan 26 1970</b>		25B. NAME OF REGISTRAR <b>John J. Brown</b>	
25C. FUNERAL DIRECTOR <b>John J. Brown</b>		ADDRESS <b>901 Hollins St. Balto. Ind. 21223</b>	

ATTACHED BOARD

RECEIVED

1955

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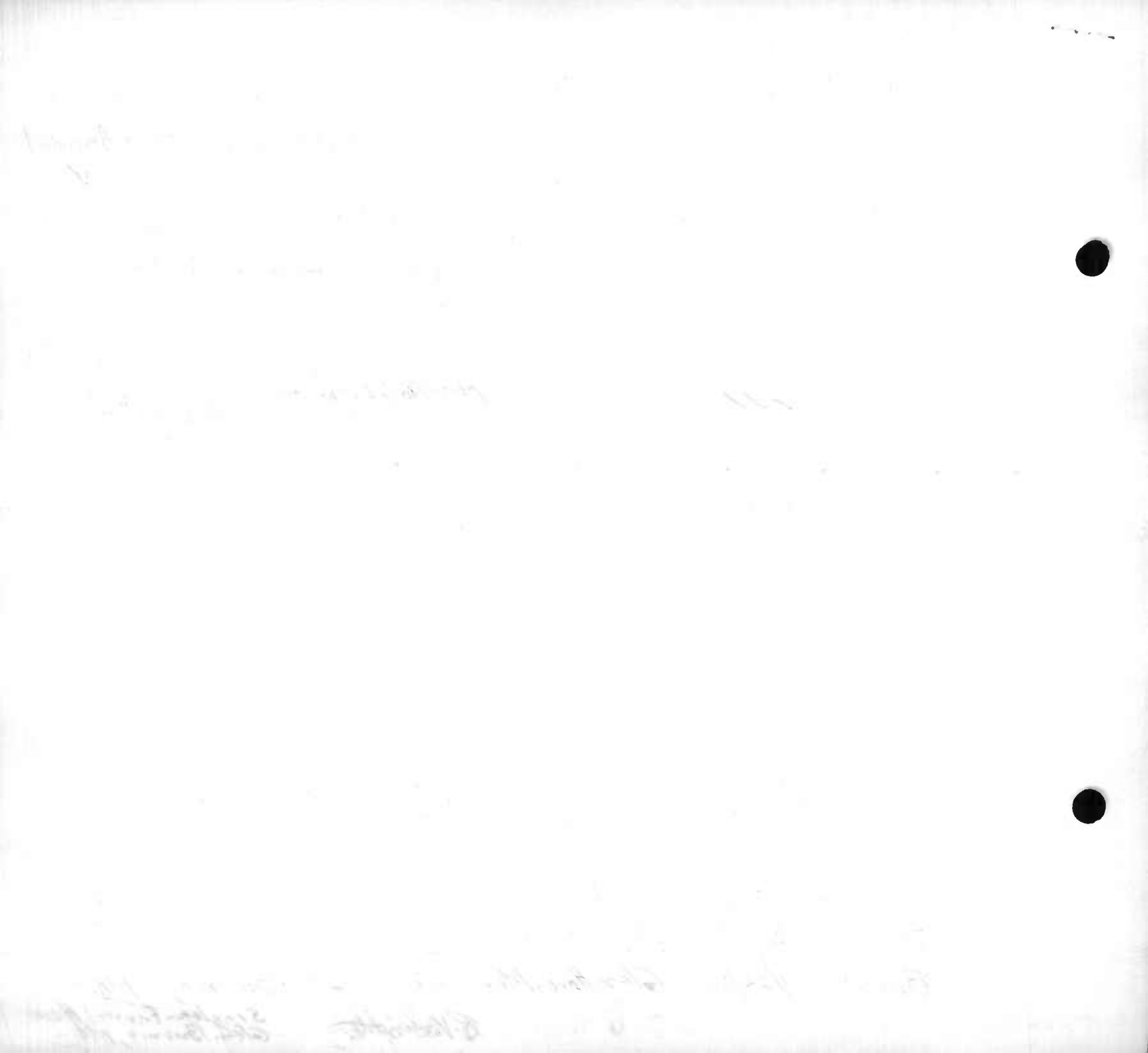
1955

1955

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

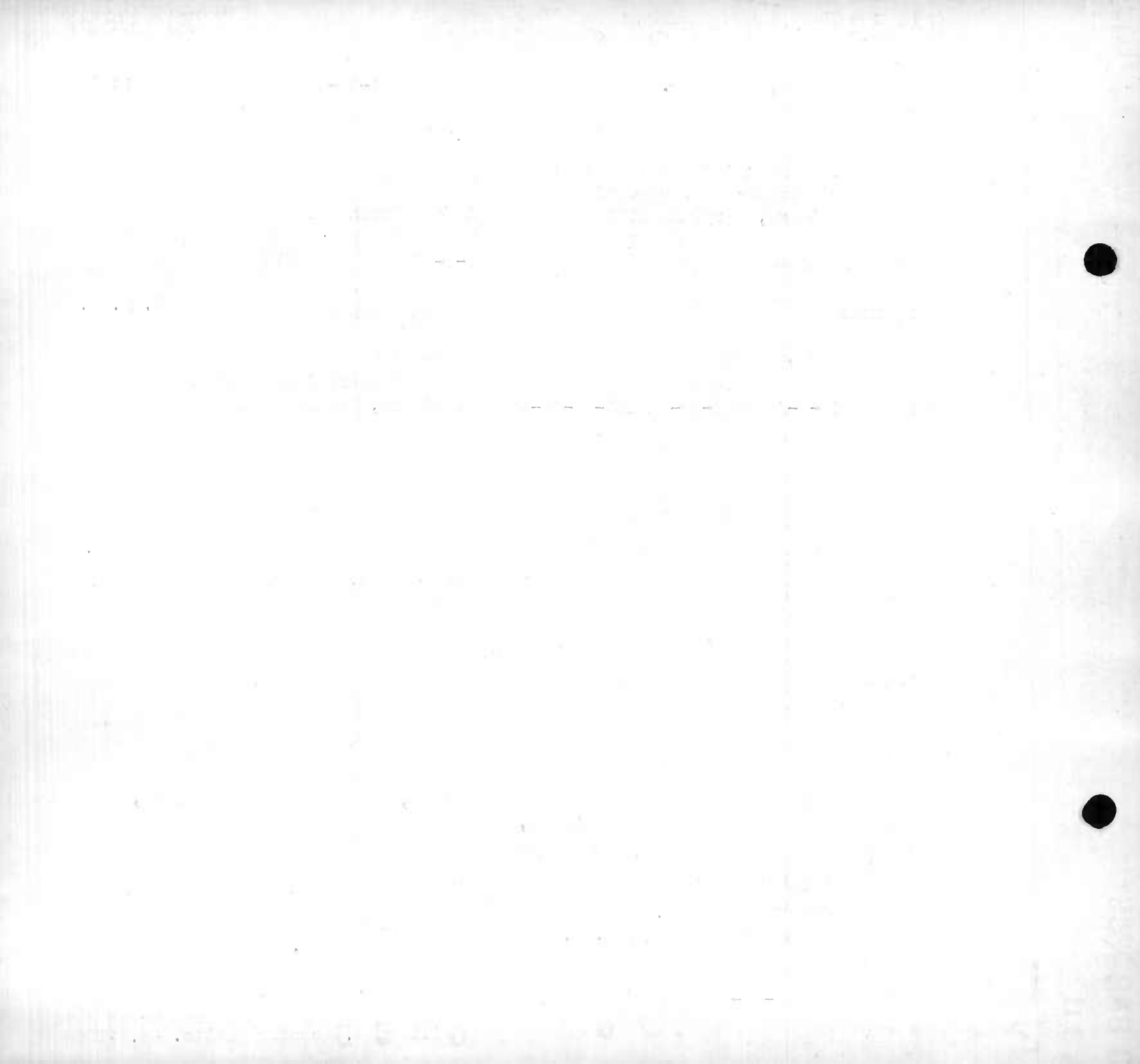
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00855	
C-623 70 00855		CERTIFICATE OF DEATH	
BIRTH NO. 69-22391		DATE AND HOUR OF DEATH 1/20/70 4:30 P.M.	
1. NAME OF DECEASED (Type as Print) Elizabeth June Christian		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen. Hosp. Baltimore Md.		A. STATE Md. B. COUNTY Baltimore	
5. SEX F		C. CITY OR TOWN Pasadena	
6. RACE W		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 4307 Belle of Georgetown Ave	
8. DATE OF BIRTH 12/4/69		9. AGE (in years last birthday) 16	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Baltimore Md	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Christian		14. MOTHER'S MAIDEN NAME Mary L. McIntyre (same)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		17. INFORMANT Mrs. Mary L. Christian Address Same As #4	
16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septum Premun Defect		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (B) Mongolism (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/18/70 to 1/20/70 that (I) (we) last saw the deceased alive on 1/20/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature] M.D. DEGREE		23B. DATE SIGNED 1/20/70	
23C. PHYSICIAN'S NAME (Type) John A. Eaddy M.D. DEGREE		23D. ADDRESS Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/70	
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS Singleton Funeral Home Glen Burnie, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325 70 00856				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 00856	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>WATKINS, Frank Jr.</b>		2. DATE AND HOUR OF DEATH <b>1-17-70 1:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2301</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		8. DATE OF BIRTH <b>9-1-22</b>	
13. FATHER'S NAME <b>Frank Watkins, Senior</b>				14. MOTHER'S MAIDEN NAME <b>Malissa ?</b>		9. AGE (In years lost birthday) <b>47</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 12-2-43 to 4-20-44</b>				16. SOCIAL SECURITY NO. <b>241-30-89-61</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
				17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of left lung</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Emphysema with pleural effusion</b>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Liver cirrhosis</b>			
				(C) <b>and arteriosclerotic, generalized</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>1-13-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 7, 1970</b> to <b>January 17, 1970</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 17, 1970</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>Hamid Mehdi</i>				23B. DATE SIGNED <b>1-17-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Hamid Mehdi, M. D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Baltimore County Maryland</b>				24E. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		24F. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JAN 26 1970</b>				25B. NAME OF REGISTRAR <b>William E. Johnson</b>		25C. FUNERAL DIRECTOR <b>8521 Loch Raven Blvd</b> <b>Balto. Md. 21204</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00857</u>	
G-355 70 00857		CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>William Goodman</u>	
2. DATE AND HOUR OF DEATH <u>1/20/70</u> <u>4</u> <u>P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2730</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore Inc.</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>7121 Park Heights Ave #15</u>		6. SEX <u>MALE</u> 7. RACE <u>WHITE</u> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>1/7/94</u> 10. AGE (in years last birthday) <u>76</u>		11. Under 1 Yr. Months: Days: 12. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTIVE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CERTIFIED PUBLIC ADJ.</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL GOODMAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MR. NORMAN GOODMAN</u>	
17. INFORMANT <u>Carlos R. Perel</u>		ADDRESS <u>7906 LONG MEADOW RD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.9 I</u>		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.U.D.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>CVA</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/19</u> 19 <u>70</u> to <u>1/20</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>1/20</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.			
23A. SIGNATURE <u>Carlos R. Perel</u>		23B. DATE SIGNED <u>1/20/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carlos R. Perel</u>		23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-22-70</u>	
24C. NAME of CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>	
25C. FUNERAL DIRECTOR <u>SOL LEVINSON</u>		ADDRESS <u>63 ROS., 6010 REISTERSTOWN ROAD</u>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00858</span>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-446</b></span> <span><b>70 00858</b></span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;"><b>JACOB SILBER</b></span>			<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><b>JANUARY 19, 1970</b></span> <span><b>11:15 A. M.</b></span> </div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>   <b>3713 CLARINTH ROAD</b>  <span style="font-size: 1.5em; margin-top: 10px;">00</span> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>   </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <span style="font-size: 1.2em;">MARYLAND</span> </div> <div> <b>B. COUNTY</b>  <span style="font-size: 1.5em;">2720</span> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <b>C. CITY OR TOWN</b>  <span style="font-size: 1.2em;">BALTIMORE</span> </div> <div> <b>D. INSIDE CITY LIMITS?</b>  <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> </div> </div> <div> <b>E. STREET AND NUMBER</b>  <span style="font-size: 1.2em;">3713 CLARINTH ROAD</span> </div>		
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1-15-1889</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">81</span>	<b>If Under 1 Yr.</b> Months: <b>Days:</b> <b>If Under 24 Hrs.</b> Hours: <b>Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MANUFACTURER</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">CLOTHING</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">AUSTRIA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">SIDNEY SILBER</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ROSE KANDEL</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">212-32-2908</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MRS. KATIE SILBER, 3713 CLARINTH ROAD</span>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <span style="font-size: 1.5em;">199.1 + 1 250.9</span>                      (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 35%;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.5em;">Carcinoma with metastases</span>                      DUE TO, OR AS A CONSEQUENCE OF:   <b>(B)</b> _____                      DUE TO, OR AS A CONSEQUENCE OF:   <b>(C)</b> _____                 </div> <div style="width: 5%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.5em;">6 mo.</span> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <div style="display: flex; justify-content: space-between; font-size: 1.5em;"> <span>Diabetes mellitus</span> <span>years</span> </div>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">19 61</span> <b>to</b> <span style="font-size: 1.2em;">1/19 19 70</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">1/16 19 70</span> <b>and that in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">1/19 19 70</span> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Bernard Burgin M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1/20/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">BERNARD BURGIN</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">3809 CLARKS LANE</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1-21-70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">SHAAREI TFILOH</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 26 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor M.D.</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>			

*(Circumvallata)*

*Pinetum*

*Pinetum*

*1/10*

*1/10*

*1/10*

*1/10*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00859</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;"><b>Eleanora M. Keelen</b></span>		<b>2. DATE AND HOUR OF DEATH</b> January 22, 1970 <span style="float: right;">5 A.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)  <span style="font-size: 2em;">00</span> 3130 Chestnut Ave.		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">1305</span> <b>C. CITY OR TOWN</b> <span style="float: right;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="float: right;">3130 Chestnut Ave.</span>			
<b>5. SEX</b> Female		<b>6. RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> May 25, 1899		<b>9. AGE</b> (In years last birthday) <span style="float: right;">70</span>		<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired	
<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Theodore H. Shipley		<b>14. MOTHER'S MAIDEN NAME</b> Mary A. Morrow			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 215-05-8071		<b>17. INFORMANT</b> <span style="float: right;">John H. Bopst - 3128 Chestnut Ave.</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Cerebral Thrombosis 1 day</span> (B) <span style="float: right;">Arteriosclerotic Cardiovascular Disease 2 1/2 years</span> (C) .....			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> None		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="float: right;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		(If in Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from September 24, 1969, to January 22, 1970, that (I) (we) last saw the deceased alive on January 15, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">L. Myrton Gaines Jr.</span>				<b>23B. DATE SIGNED</b> 1/23/70	
<b>23C. PHYSICIAN'S NAME</b> (Type) L. MYRTON GAINES JR.				<b>23D. ADDRESS</b> 7800 YORK RD.	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> 1/24/70		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Pine Grove Cemetery	
<b>24D. LOCATION</b> (City, town, or county) (State) Rayville, Md.		<b>25A. DATE RECEIVED BY HEALTH DEPT.</b> JAN 26 1970			
<b>25B. NAME OF REGISTRAR</b> Ann Donovan		<b>25C. FUNERAL DIRECTOR</b> <span style="float: right;">3818 Roland Ave.</span>			

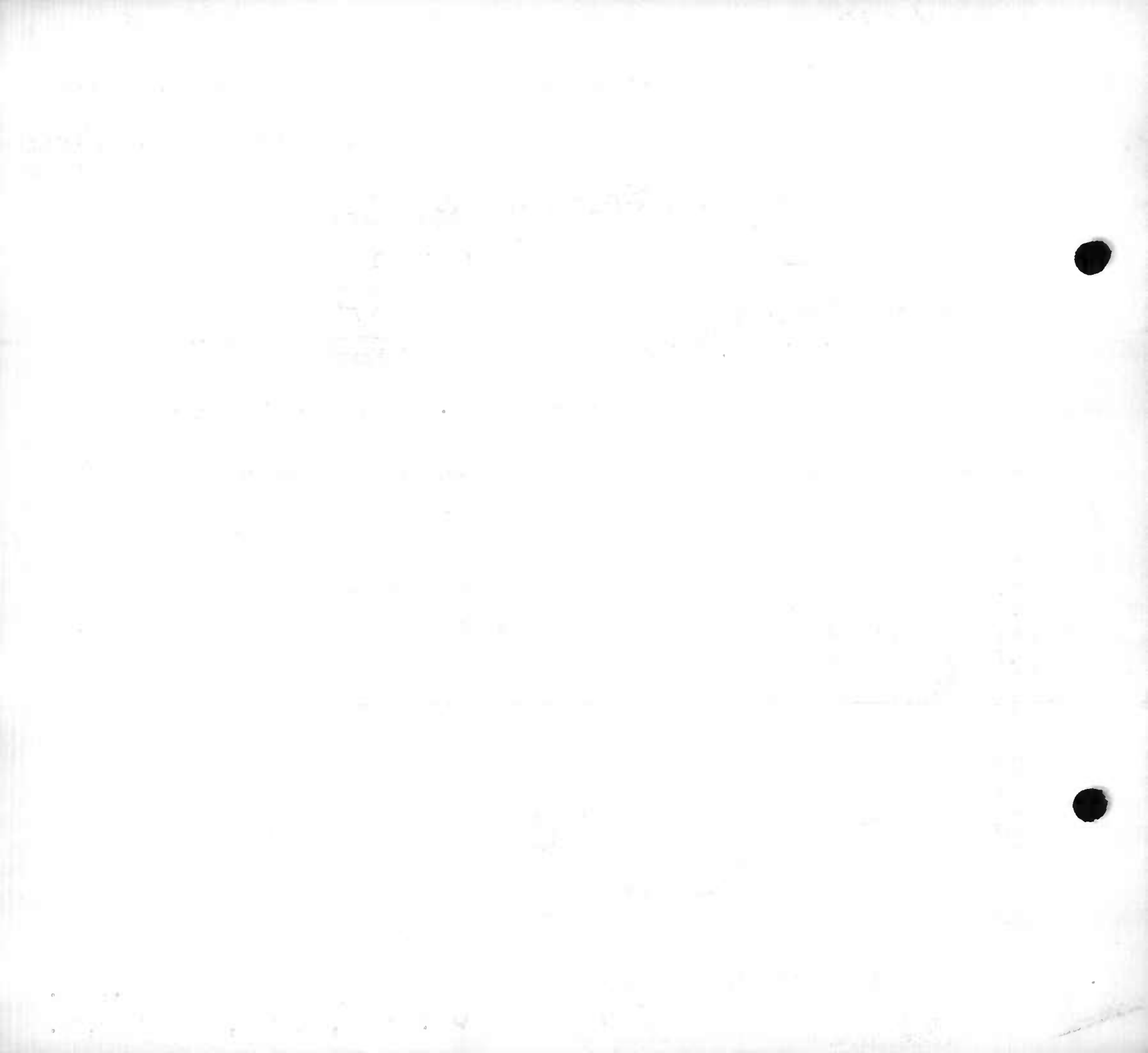
1800 YORK RD

L. Merton Gainsbury

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

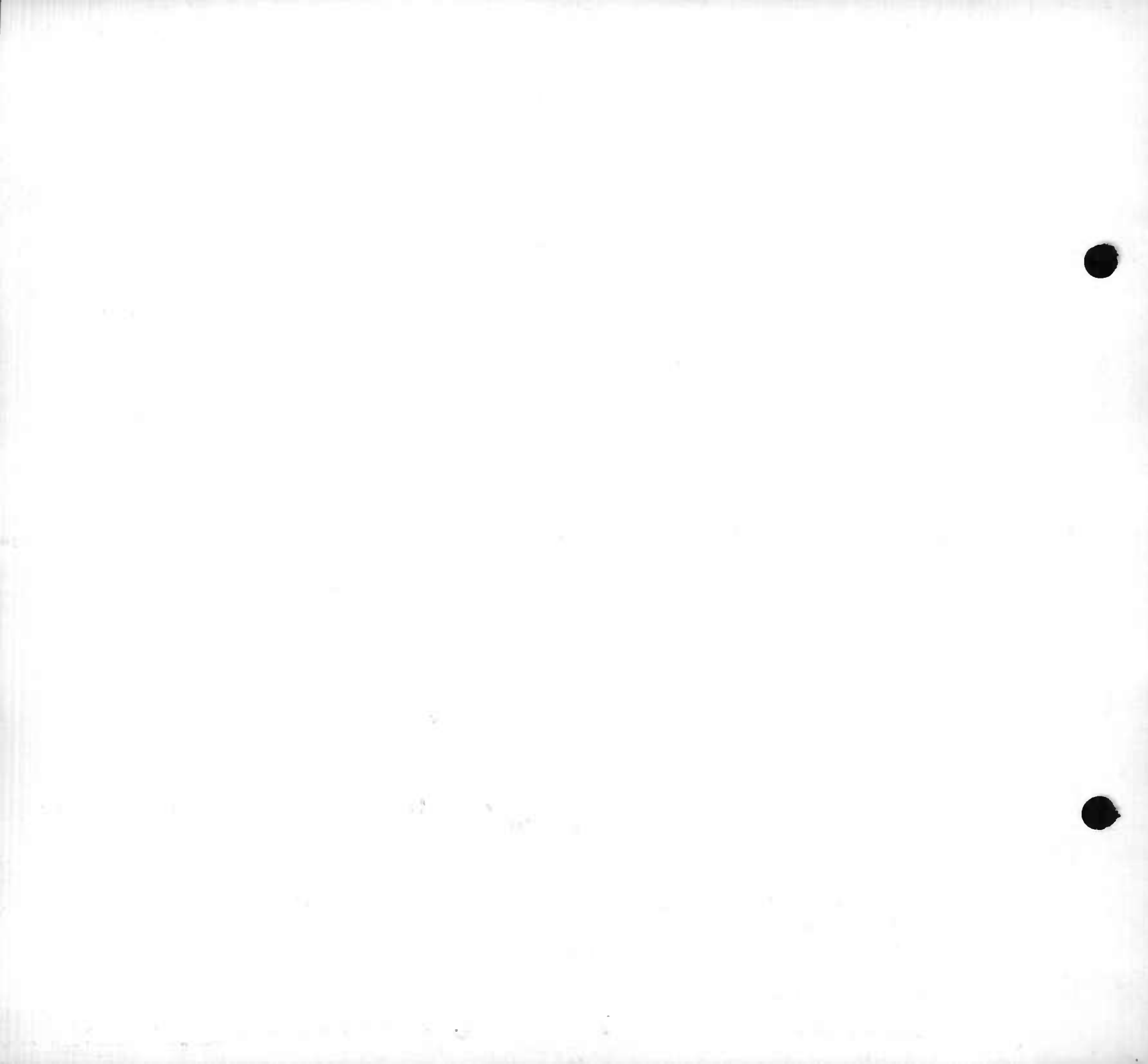
H-520		70 00860		BALTIMORE CITY HEALTH DEPARTMENT		X		70 00860	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William R. HAINES</b>				2. DATE AND HOUR OF DEATH <b>11/21/70 @ 8 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> C. COUNTY <b>Frederick</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINA Hospital Baltimore</b>						C. CITY OR TOWN <b>Town</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER <b>Rt 2 Box 290 Mt Airy</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/12</b>		9. AGE (In years last birthday) <b>57</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BUILDER</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William P. Haines</b>				14. MOTHER'S MAIDEN NAME <b>Naomi Esworthy</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-10-5779</b>		17. INFORMANT <b>Mrs. Hazel Frizzell Same As #4</b>			
18. <b>5335 X I</b> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Broncho pneumonia</b>						<b>8 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>G.I.T. PATHOLOGY &amp; ?</b>						<b>10 days</b>			
(B) <b>G.I.T. PATHOLOGY &amp; ?</b>									
(C) <b>Cerebral embolism</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Cerebral embolism Bptm of del CVA</b>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>1- VI 1970</b> to <b>1/21 1970</b> that (1) <b>last</b> saw the deceased alive on <b>8 AM on 1/21 1970</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>P B Donovan</b>						23B. DATE SIGNED <b>1/21/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>P B Donovan</b>						23D. ADDRESS <b>Sina Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>1/23/1970</b>		<b>Prospect Cemetery</b>		<b>Frederick Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Walters</b>		25C. FUNERAL DIRECTOR <b>CU M. Walters, Box 241, Sykesville, Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.	
M-610		70 00861		70 00861	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
THERESA MURPHY		1-21-70		3:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Baltimore General Hospital		Maryland Baltimore		5300	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				New York	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Anthony Guccia		Eunnie		USA	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Matthew V. (Husband)	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Respiratory Arrest	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Anemia	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		Chronic Glomerulonephritis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-15-70 to 1-21-70 that (I) (we) last saw the deceased alive on 1-21-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Virginia Y. Faust, M.D.		1-21-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
VIRGINIA Y. FAUST, M.D.		South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-24-1970		St. John's	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 26 1970		Robert A. Cook		Wm. Cook Brooks	
				ADDRESS	
				Towson, 1050 York Road	
				Towson, Maryland 21204	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 00862</span>	
<div style="font-size: 1.5em; font-weight: bold;">L-358</div> <div style="font-size: 1.5em; font-weight: bold;">70 00862</div>		<div style="font-size: 1.5em; font-weight: bold;">X</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)	
James Loudin		1- 21- 1970		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto Co. 53-00	
<div style="font-size: 2em; font-weight: bold; text-align: center;">CERTIFICATE AMENDED</div> 90 House in the Pines Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Box 35 Rt#1 White Marsh, Maryland 21162			
5. SEX Male Female	6. RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-1889	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Czar W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nicholas Loudin		14. MOTHER'S MAIDEN NAME Amanda Hicks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-12-4395A		17. INFORMANT Lillian Schlogel Box 35 Rt.#1 White Marsh Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) <i>Arteriosclerotic Cardiovascular Disease</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Chronic Brain Syndrome</i>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>11/13/1969</u> to <u>1/2</u> 19 <u>70</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>1/2/1970</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>Robert E. Bradley</i>				23B. DATE SIGNED 1/23/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-70		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Fullerton, Balto, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970			
25B. NAME OF REGISTRAR <i>Robert E. Bradley</i>		25C. FUNERAL DIRECTOR Lillian Schlogel			
ADDRESS Lillian Schlogel Box 35 Rt.#1 White Marsh Md.					

V.S. 153

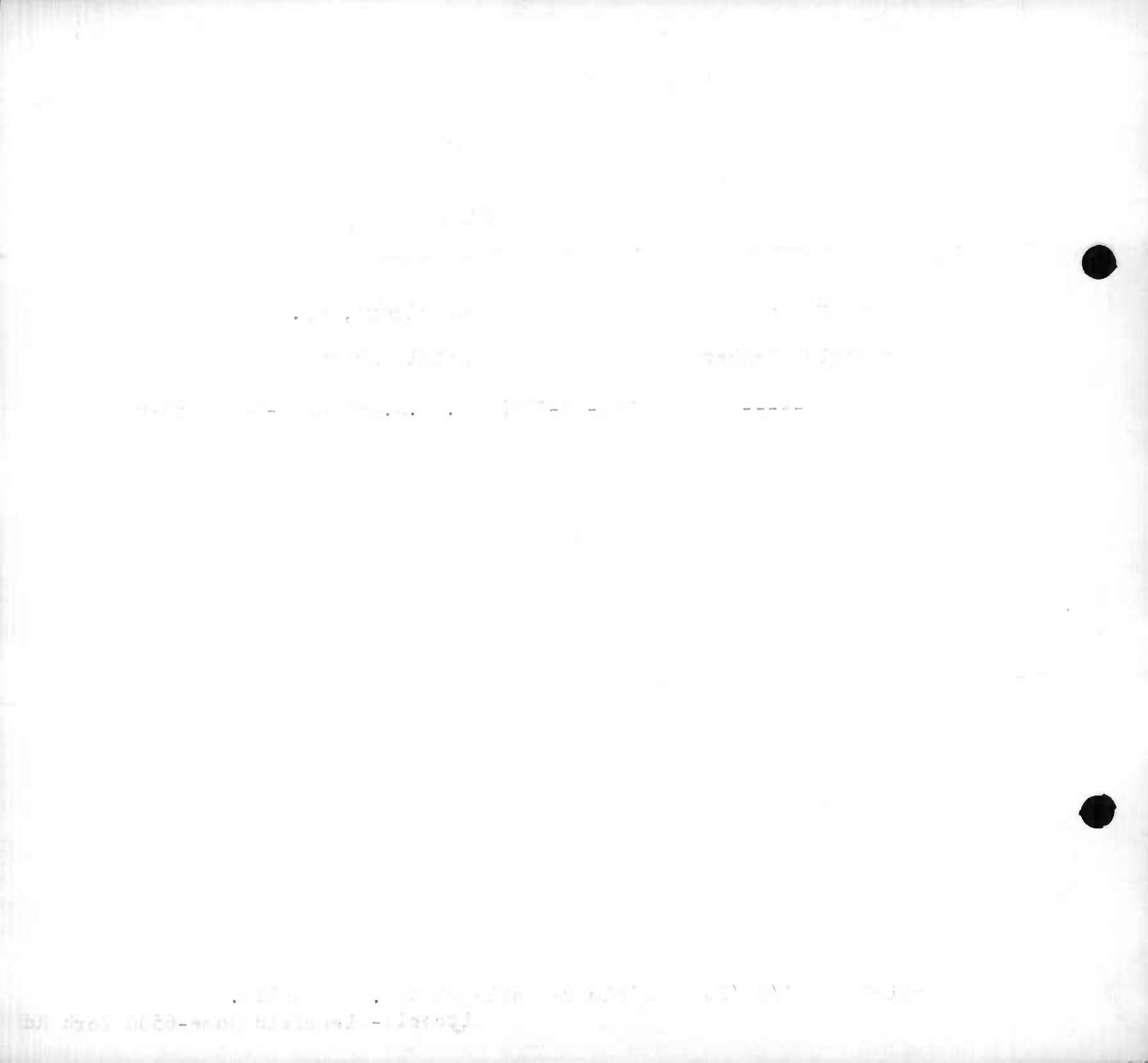
2-3-70

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>70 00863</u>	
C-352 70 00863 C-535			
BIRTH NO. <u>70 00863</u>		1. NAME OF DECEASED (Type or Print) <u>ELEANOR CANTANESE (CATANESE)</u>	
2. DATE AND HOUR OF DEATH <u>JANUARY 22, 1970 4:20 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MONTEBELLO HOSPITAL</u> <u>91</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>8461 WATER OAK ROAD</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1917</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>52</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Frederick Denker</u>		14. MOTHER'S MAIDEN NAME <u>Hattie McNew</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-01-2313</u>	
17. INFORMANT		ADDRESS <u>Mr. S.J. Catanese-8461 Water Oak</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma neck</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized metastases</u> <u>Primary site unknown.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>8-18-1969</u> to <u>JAN 22, 1970</u> that (I) (we) lost saw the deceased alive on <u>JAN 22, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Mohammad Inayatullah M.D.</u>		23B. DATE SIGNED <u>1-22-1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>MOHAMMAD INAYATULLAH M.D.</u>		23D. ADDRESS <u>MONTEBELLO HOSPITAL, BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/26/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Balto.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Mitchell-Wiedefeld</u>	
25C. FUNERAL DIRECTOR <u>Home-6500 York Rd</u>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00864</span>	
BIRTH NO. <span style="float: left;">B-631</span>				70 00864	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Ernest C. Bradford			January 19, 1970 10 <sup>00</sup> P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
100 Long Green Nursing Home			Maryland Balto. 5300		
5. SEX			6. RACE		
Male			White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Sept. 8, 1887		
9. AGE (In years last birthday)			10. Under 1 Yr. Months Days		
82			11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
Retired J D. Lucas Printing Co.			Hindsboro, Ill.		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Morris Bradford			?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			216-03-6751		
17. INFORMANT			ADDRESS		
James M. Bradford			Irvington N.Y.		
184 S. Buckhout St			10333		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Bronchopneumonia		
ANTECEDENT CAUSES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			5 days		
II			Parkinson's Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			4 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			22. I certify that (I) (this hospital) attended the deceased from January 19 1970 to January 19 1970		
that (I) last saw the deceased alive on January 19 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) view the body after death.			23A. SIGNATURE		
Dr. A. Allan Spier			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. A. Allan Spier			1501 Pentridge Rd. Balto. Md. 21212		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			1/22/70		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Bee Tree Cemetery			Darkton, Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JAN 26 1970			Mitchell-Wiedefeld Home 6500 York Rd.		

Page 1 of 1

James H. Haddock  
1000 1st St.  
New York, N.Y.  
10001

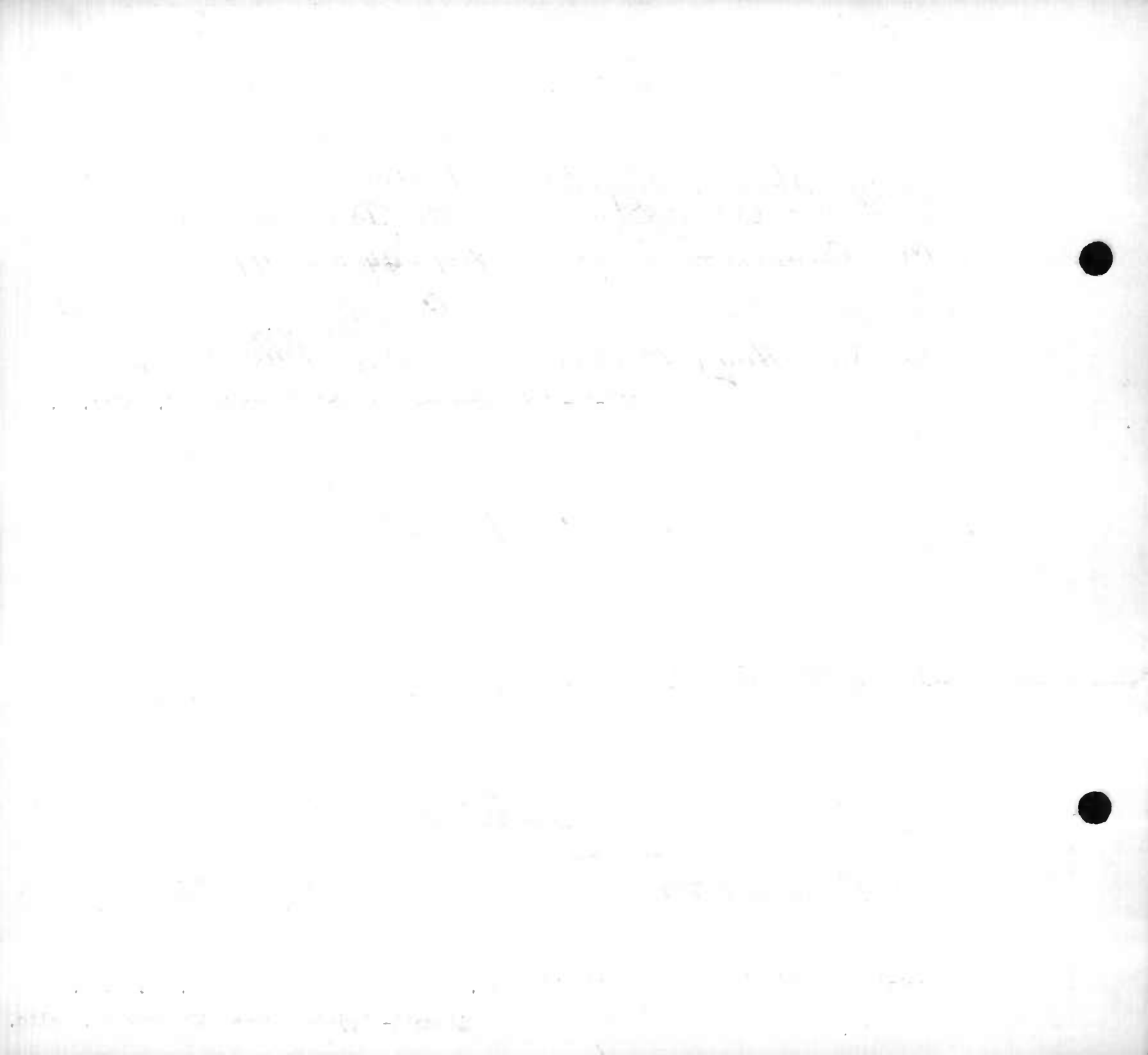
James H. Haddock  
1000 1st St.  
New York, N.Y.  
10001

James H. Haddock  
1000 1st St.  
New York, N.Y.  
10001

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 00865	
BIRTH NO. <b>B-463</b>		70 00865		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>George W. Bullard</b>				2. DATE AND HOUR OF DEATH <b>Jan. 23 1970 6:07 AM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hospital 33rd and Calvert Sts.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital 33rd and Calvert Sts.</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>50 Dunkirk Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1908</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sales representative</b>			11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Mr. Wm. Henry Bullard</b>			14. MOTHER'S MAIDEN NAME <b>Mrs. Lelia XXXXX Webb</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>218-18-3136</b>		17. INFORMANT ADDRESS <b>Margaret Bullard 50 Dunkirk Rd. Balto. Md.</b>		
18. <b>153.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-resp. arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>large bowel obstruction - carcinoma</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>Jan. 19 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>large bowel obstruction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 16 1970</b> to <b>Jan 23 1970</b> that (I) (we) lost saw the deceased alive on <b>Jan 23 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Jan 23 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>[Name]</b>				23D. ADDRESS <b>[Address]</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/26/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Co. , Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto.</b>			





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 00866	
T-000 70 00866		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mrs. Mary Winter Toohey</b>		2. DATE AND HOUR OF DEATH <b>January 21, 1970 9:55 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto co</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Jenkins Memorial Hospital</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>		C. CITY OR TOWN <b>Towson</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 4, 1885</b> 9. AGE (In years last birthday) <b>84 years</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Frank A. Winter</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lannahan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-6297</b>	
17. INFORMANT ADDRESS <b>Jenkins Memorial Hospital, 1000 Caton Ave. Baltimore, Md. 21229</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease</b>		(B) <b>x years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> 19 <b>70</b> to <b>1/21</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <b>J. Raymond Gladue</b>		23B. DATE SIGNED <b>1/22/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. J. Raymond Gladue</b>		23D. ADDRESS <b>Jenkins Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>1/24/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faby</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell Wiedefeld Home 6500 York Rd. Balto.</b>			

120

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100

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00867	
<div style="display: flex; justify-content: space-between;"> <span>3-200 70 00867</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <b>GEORGE SACKS SR.</b>		2. DATE AND HOUR OF DEATH <b>JAN. 20, 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>GOULD NURSING HOME BELAIR RD.</b>		C. CITY OR TOWN <b>ESSEX</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/21/94</b>		9. AGE (In years last birthday) <b>75</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>213-07-7189</b>		17. INFORMANT <b>JENNIE SACKS</b>	
18. <b>348.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE heart failure</b>		CAUSE OF DEATH <b>Angiotrophic lateral sclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 19 69</b> to <b>Jan. 20, 1970</b> , that (I) (we) last saw the deceased alive on <b>Jan 16 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert Roubenoff M.D.</b>		23B. DATE SIGNED <b>1/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ROBERT ROUBENOFF M.D.</b>	
23D. ADDRESS <b>Fuller Med. Group Baltimore 6, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BELAIR MEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BEL AIR MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>	
25B. NAME OF REGISTRAR <b>J.C. CONNELLY SONS</b>		25C. FUNERAL DIRECTOR <b>300 MACC</b>		25D. ADDRESS	

10/1/44

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200		70 00868		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00868	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Dasch, EIMER GEORGE</u>				2. DATE AND HOUR OF DEATH <u>1-21-70</u> <u>1:15</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>05-15-29</u> 9. AGE (In years last birthday) <u>76</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>American</u>				13. FATHER'S NAME <u>Charles William Dasch</u>			
14. MOTHER'S MAIDEN NAME <u>Florence Knight</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Edith G. Dasch-4814 Liberty Hghts. Ave.</u>			
18. CAUSE OF DEATH <u>395.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiac arrest</u> <u>Chronic cardiac failure</u> <u>aortic stenosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-26-69</u> to <u>1-21-70</u> that (I) (we) last saw the deceased alive on <u>1-21-70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Werner Meier</u>				23B. DATE SIGNED <u>1-21-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>WERNER MEIER</u>				23D. ADDRESS <u>Armatost Funeral Chapel-4600 Liberty Hts.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-24-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Armatost Funeral Chapel-4600 Liberty Hts.</u>		ADDRESS	

1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th

\* w m

[illegible]

5-517-AM

3249-7017

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*Handwritten signature*

9.31.3M 3349300

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-140		70 00869		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00869	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>GABEL TERESA</b>			
2. DATE AND HOUR OF DEATH <b>1. 15. 70</b>				2. 20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Maryland</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3520 N HILTON ST</b>							
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-94</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ASHBURN NURSING HOME-3520 N. Hilton St.</b> <b>CHARL</b>			
18. <b>486X I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<b>12. 25 pm</b> <b>1. 14. 70</b> <b>to</b> <b>2. 20 pm</b> <b>1. 15. 70</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Anaemia</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1. 14. 1970</b> to <b>1. 15. 1970</b> , that (I) (we) last saw the deceased alive on <b>1. 15. 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>G. Nanes M.D.</b>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>G NANES M.D.</b>				23D. ADDRESS <b>Lutheran Hosp Ashburn St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Armacost Funeral Chapel-4600 Liberty Hts</b>		ADDRESS	

Jan 11

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approved by Medical Examiner.		BALTIMORE CITY HEALTH DEPARTMENT		70 00870	
L-500		70 00870		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.		70 00870	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Edward M. Loane		1/23/70 1:25 A.M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Md. General Hospital		Md.		2102	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
48		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		855 N. Henry St.		(21230)	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/8/1905	64	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mechanic		Rogers Co.		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph D. Loane		Cynthia Lockard		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		26-10-7401		Mrs. Margaret Loane - 855 N. Henry St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		1-Acute myocardial infarction,		sudden	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		2-Arteriosclerotic C.V.D., Class II-IV		10 yrs. +	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		3-Moderately severe obstructive disease and (c) asthma, duration 10 years +.		bronchial	
II		4-Generalized arteriosclerosis, moderate		10 years.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (the deceased) attended the deceased from 1950 to present 19 that (I) last saw the deceased alive on January 20th, 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (No) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
R.V. Rangle, M.D.		1/23/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
R.V. Rangle, M.D.		2938 St. Paul Street, Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/27/70		Landon Park Cem.	
24D. LOCATION (City, town, or county)		24E. DATE		24F. NAME of REGISTRAR	
Baltimore				JAN 26 1970	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 26 1970		J. E. Rangle		J. E. Rangle & Son Inc.	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
909 Hollis St.		25th md.			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

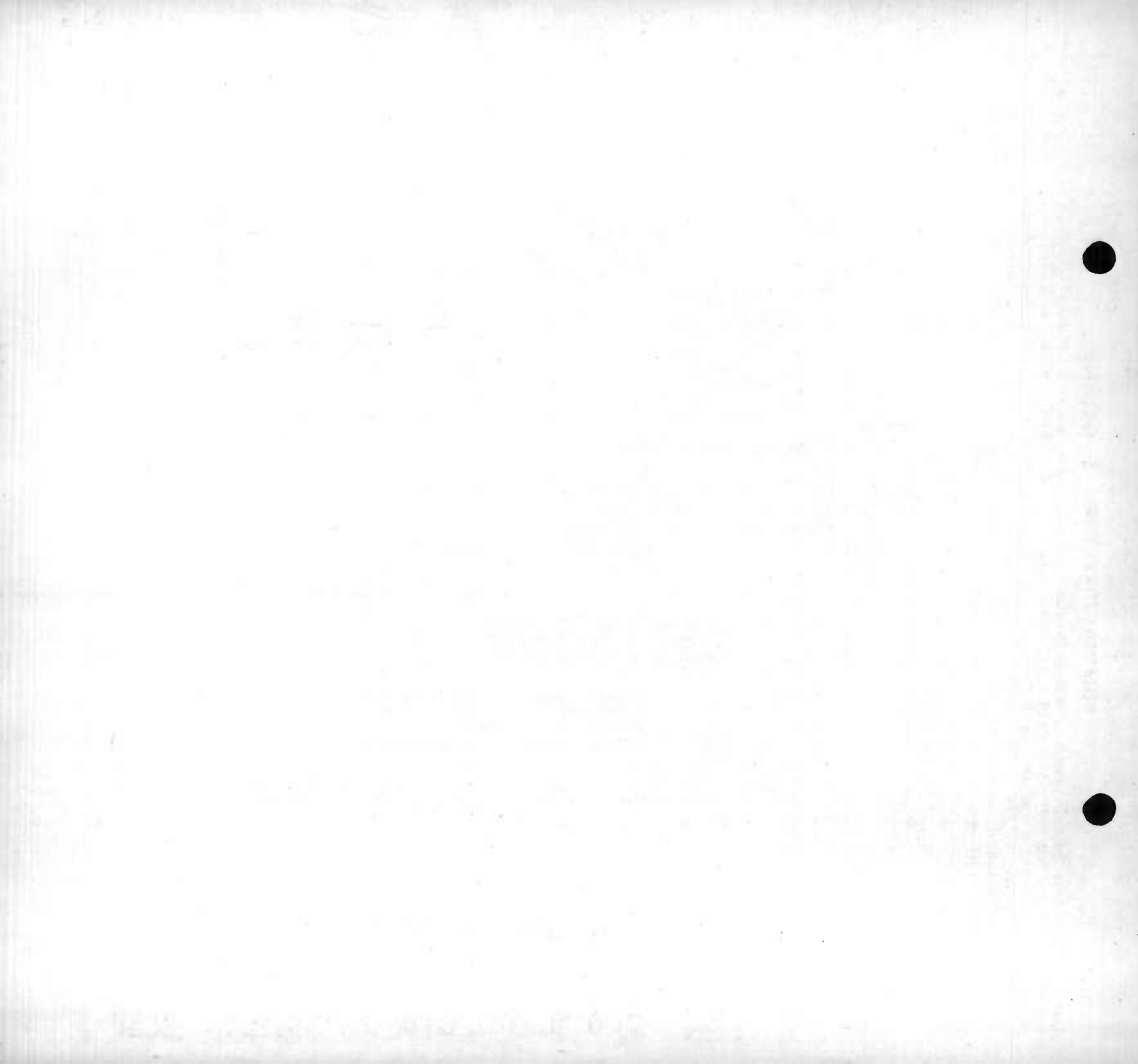
P-620 70 00871		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00871	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>PRIDE ESTELLE MORRIS</i>		2. DATE AND HOUR OF DEATH <i>JANUARY 11, 1970 11:10 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE & COUNTY <i>Maryland Baltimore Co.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>#3 Dunkirk Apartments 21222</i>		6. DATE OF BIRTH <i>6-2-88</i>		7. AGE (in years last birthday) <i>81</i>	
8. SEX <i>Female</i>		9. RACE <i>White</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>4940 Eastern Avenue</i> <i>BCH Records-Baltimore, Maryland 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Pulmonary Edema</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic C.V. disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>No Carcinoma of the heart</i> (C) <i>Probable metastasis to liver and stomach</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>January 10</i> 19 <i>70</i> to <i>January 11</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>January 11</i> 19 <i>70</i> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Francisco Tejada, MD</i>		23B. DATE SIGNED <i>January 11, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Francisco Tejada, MD</i>	
23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Avenue, Balto., Md. 21224</i>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-15-70</i>	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR		24E. LOCATION (City, Ave., county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR'S ADDRESS	
VS 150-REV. 1/1/68		ANATOMY BOARD OF MARYLAND		UNIVERSITY MEDICAL SCHOOL	
MORTUARY SERVICE - BCHD					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										X		REG. NO. 70 00872 4	
T-635 70 00872										BIRTH NO. 70-00041		THORNTON	
1. NAME OF DECEASED (Type or Print) Baby Roy Thornton										2. DATE AND HOUR OF DEATH 1-2-70 7:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Prince Georges 6600			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Jew Hosp.										C. CITY OR TOWN 7335 Pine Rd		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Laurel Maryland										5. SEX M		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH 70 1-2-70		9. AGE (in years last birthday) 2	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA										13. FATHER'S NAME Benjamin		14. MOTHER'S MAIDEN NAME Linda Thornton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.		17. INFORMANT Mother	
18. 777 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-2 1970 and that (I) (we) last saw the deceased alive on 1-2 1970 and that in (my) (our) opinion death occurred on the date 1-2 1970 and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE A. Meloc		23B. DATE SIGNED 1-2-70	
23C. PHYSICIAN'S NAME (Type) ALEYDE A. MELOCO										23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) 1-26-70										24B. DATE 1-26-70		24C. NAME OF CEMETERY CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)										25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS										25D. MORTUARY SERVICE - BCHD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-250 70 00873		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 70-00848		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>William Harold Hogan</i>		2. DATE AND HOUR OF DEATH <i>1-20-70</i> <i>9 20</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Room # 7</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General</i>		C. CITY OR TOWN <i>Roadside</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <i>1/20/70</i> 9. AGE (In years last birthday) <i>2 48</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Harold William Hogan</i>		14. MOTHER'S MAIDEN NAME <i>Sandra Lee Rayner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>mother</i>		ADDRESS <i>Same</i>	
18. <i>769.41</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Prematurity</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Vallop</i>		23B. DATE SIGNED <i>1-20-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>VALLOP</i>		23D. ADDRESS <i>Med - General Hosp.</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Retained</i>		24B. DATE <i>1-22-70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Med Gen Hospital</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>	
25C. FUNERAL SERVICE <i>MOOREHEAD SERVICE - BOND</i>		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 00874	
BIRTH NO. 70-00847				DATE AND HOUR OF DEATH 1-20-70 1920			
1. NAME OF DECEASED (Type or Print) <i>Harold William Hogan Jr.</i>				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Turner</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General</i>				C. CITY OR TOWN <i>Fordale</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/20/70</i>	
9. AGE (in years last birthday) <i>2</i>		10. AGE (in years last birthday) <i>39</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Harold William Hogan Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Sandra Lee Roegner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>mother</i> ADDRESS <i>Same</i>	
18. <i>769.4 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Prematurity</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				_____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				_____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1-20-1970</i> to <i>1-20-1970</i> that (I) (we) last saw the deceased alive on <i>1-20-1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Vallop</i>				23B. DATE SIGNED <i>1-20-70</i>			
23C. PHYSICIAN'S NAME (Type) <i>VALLOP</i>				23D. ADDRESS <i>md - General Hosp.</i>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <i>1-22-70</i>		24C. NAME of CEMETERY or CREMATORY <i>md Gen Hospital</i>		24D. LOCATION (City, town, or county) (State) <i>MDR KIRK</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00875	
CERTIFICATE OF DEATH				REG. NO. 70 00875	
1. NAME OF DECEASED (Type or Print) <i>William Lloyd A McGIRT</i>		2. DATE AND HOUR OF DEATH <i>JAN 16, 1970 2:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <i>Twins A Md. Gen. Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1204</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2033 Guilford Ave 3121P</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 16, 1970</i>	9. AGE (In years last birthday) <i>2</i>	10. If Under 1 Yr. Months Days <i>43</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>William Lloyd Parish</i>		14. MOTHER'S MAIDEN NAME <i>Marie Kitty Alexander</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i> ADDRESS <i>Same</i>	
18. <i>769.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Immature</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>premature rupture of membrane</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 w</i> <i>5d.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 16 1970</i> to <i>Jan 16 1970</i> that (i) (we) last saw the deceased alive on <i>Jan 16 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nandoh Yang, M.D.</i>				23B. DATE SIGNED <i>JAN. 16, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>NANDOH YANG</i>		23D. ADDRESS <i>M. ANATOMY BOARD OF MARYLAND</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-19-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taber, M.D.</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>	



# FUNERAL DIRECTOR: IMPORTANT

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M-263 70 00876		BALTIMORE CITY HEALTH DEPARTMENT		70 00876	
BIRTH NO. 70-00847		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Charles</i>		2. DATE AND HOUR OF DEATH <i>JAN. 16, 1970</i>		2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>TWINS B</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1204</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>md. Gen Hosp</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>JAN 16, 1970</i>	
				9. AGE (In years last birthday) <i>2 22</i>	
13. FATHER'S NAME <i>William Lloyd Smith</i>		14. MOTHER'S MAIDEN NAME <i>Marie Kitty Alexander</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
				17. INFORMANT <i>Mother</i>	
18. 769.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH <i>Immature</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>premature rupture of membrane 5d.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 w</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 16</i> 19 <i>70</i> to <i>Jan 16</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>Jan 16</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Namdoh Yang, M.D.</i>				23B. DATE SIGNED <i>JAN. 16, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>NAMDOH YANG, M.D.</i>				23D. ADDRESS <i>ANATOMY BOARD OF MARYLAND</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-19-70</i>		24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION <i>City, State</i>		24E. LOCATION <i>(State)</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00877</u>	
<div style="display: flex; justify-content: space-between;"> <span>U-512</span> <span>70 00877</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>UMBACH JOHN H.</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 20, 70 12.10' P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL OF BALTIMORE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2854</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>609 N. Chapelgate Banc #29.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/10</u>	9. AGE (In years last birthday) <u>59</u>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sun Papers</u>		11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John A. Umbach</u>			
14. MOTHER'S MAIDEN NAME <u>Waxweather</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Balto. Md. 21229</u> <u>Mrs. Florence M. Umbach 609 N. Chapel Gate Lane</u>			
18. <u>450 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Circulatory Shock.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulmonary Emboli</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Anuria and Hepatic Failure sec. to shock.</u>					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>70</u> to <u>1/20</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> <u>M.D.</u> DEGREE				23B. DATE SIGNED <u>1/20/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANDREAS A. PETRAS</u> <u>M.D.</u> DEGREE				23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 23, 1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>	
24D. LOCATION <u>Woodlawn, Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Balto. Md. 21229</u> <u>G. Truman Schwab 5151 Balto. National Pike</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. 70 00878											
R-325 70 00878											
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) MERLE W. BOUTSON						2. DATE AND HOUR OF DEATH 11/19/70 1:05 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland						C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore Md YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 1007 Pleasant Oaks Rd. 21204											
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/16		9. AGE (In years last birthday) 53		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Mill Foreman Beth Steel						10B. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Md.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CHARLES M BOUTSON						14. MOTHER'S MAIDEN NAME Hydia MERCER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Canadian						16. SOCIAL SECURITY NO. 21207 8186					
17. INFORMANT Patient Family						ADDRESS					
18. 4/10/9 I CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction 37 hours											
(B) Coronary Artery Disease 3 yrs											
(C) Arterial Sclerotic Cardiovascular Disease (!)											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None											
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/19 to 1/19 1970 that (I) (we) last saw the deceased alive on 1/19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Harold J. Kaplan M.D. DEGREE											
23B. DATE SIGNED 11/19/70											
23C. PHYSICIAN'S NAME (Type) Harold J. Kaplan M.D. DEGREE											
23D. ADDRESS Univ. of Maryland Hosp.											
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE 1-22-70				24C. NAME OF CEMETERY OR CREMATORY Pipe Creek Cem			
24D. LOCATION New Windsor, Carroll Co Md											
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970				25B. NAME OF REGISTRAR Robert E. Taylor M.D.				25C. FUNERAL DIRECTOR Burgee Funeral Home 13216 Md			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-520		70 00879		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00879	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Harvey Ingoe				2. DATE AND HOUR OF DEATH JAN 21, 1970 6 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford Co. 62.32				C. CITY OR TOWN Bel Air D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Friedler's Guest House 2449 Shirley Avenue Baltimore, Maryland		E. STREET AND NUMBER 118 West Ring Factory Road							
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1918	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collection Mgr.		10B. KIND OF BUSINESS OR INDUSTRY Finance Company		11. BIRTHPLACE (State or foreign country) (Gals) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (DECEASED) James Alexander Ingoe		14. MOTHER'S MAIDEN NAME (DECEASED) Dixie Savannah Harmon							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW#2		16. SOCIAL SECURITY NO. 215-12-4794		17. INFORMANT (Daughter) 838-9160 Mrs. Cheryl A. Rexroth		ADDRESS 118 West Ring Factory Road Bel Air, Maryland 21014			
18. I 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart disease (C) none				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week 1 year			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from March 3 1969 to Jan 21 1970, that (I) (we) last saw the deceased alive on Jan 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Manuel Levin		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/21/70					
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN		23D. ADDRESS M.D. 6101 PARK HOTS AVE. BALTO-15 140,							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JAN. 23, 1970		24C. NAME OF CEMETERY or CREMATORY FAWN GROVE Methodist Church Cem.		24D. LOCATION (City, town, or county) (State) FAWN GROVE, York Co., PENNSYLVANIA			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			

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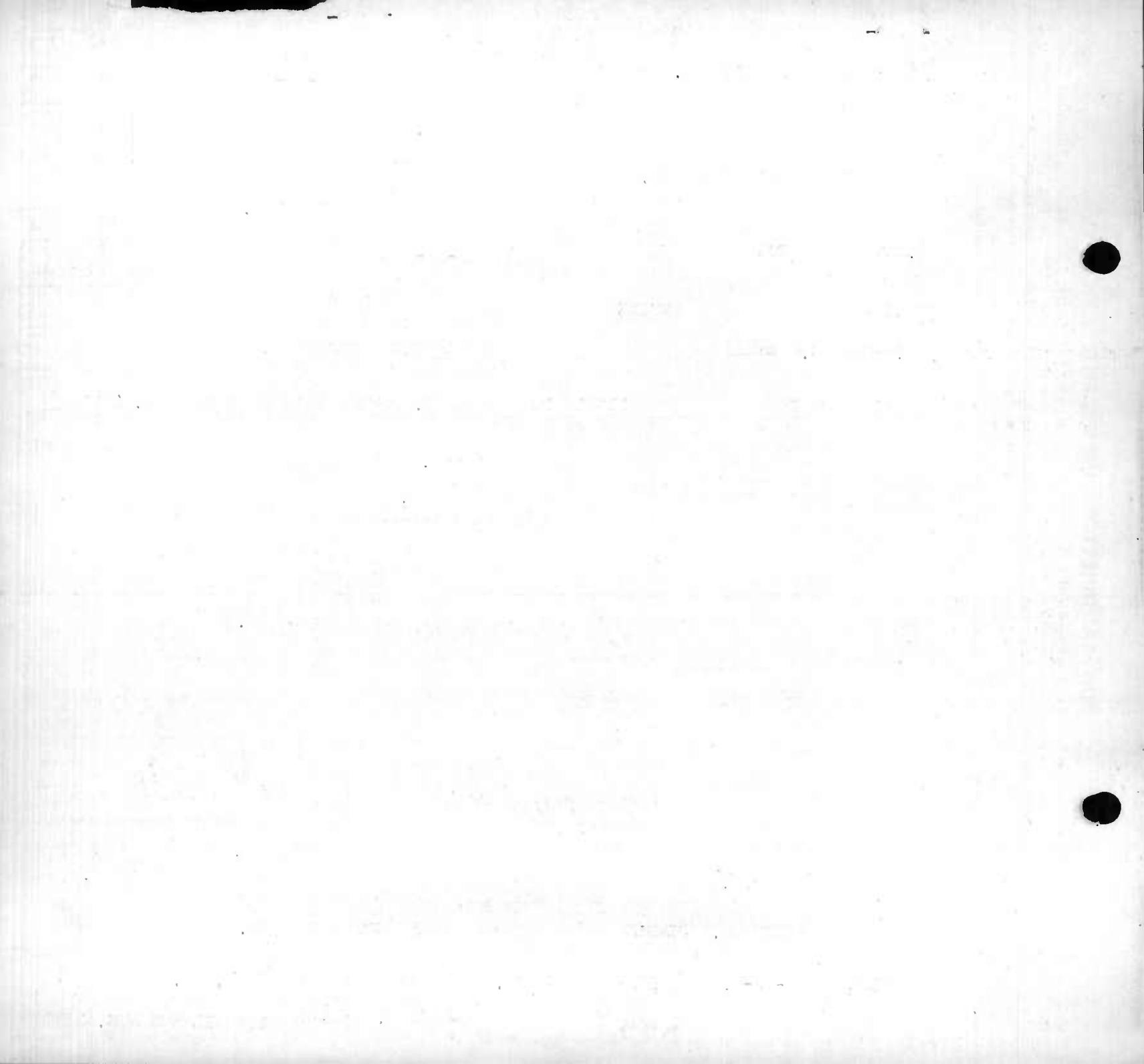
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

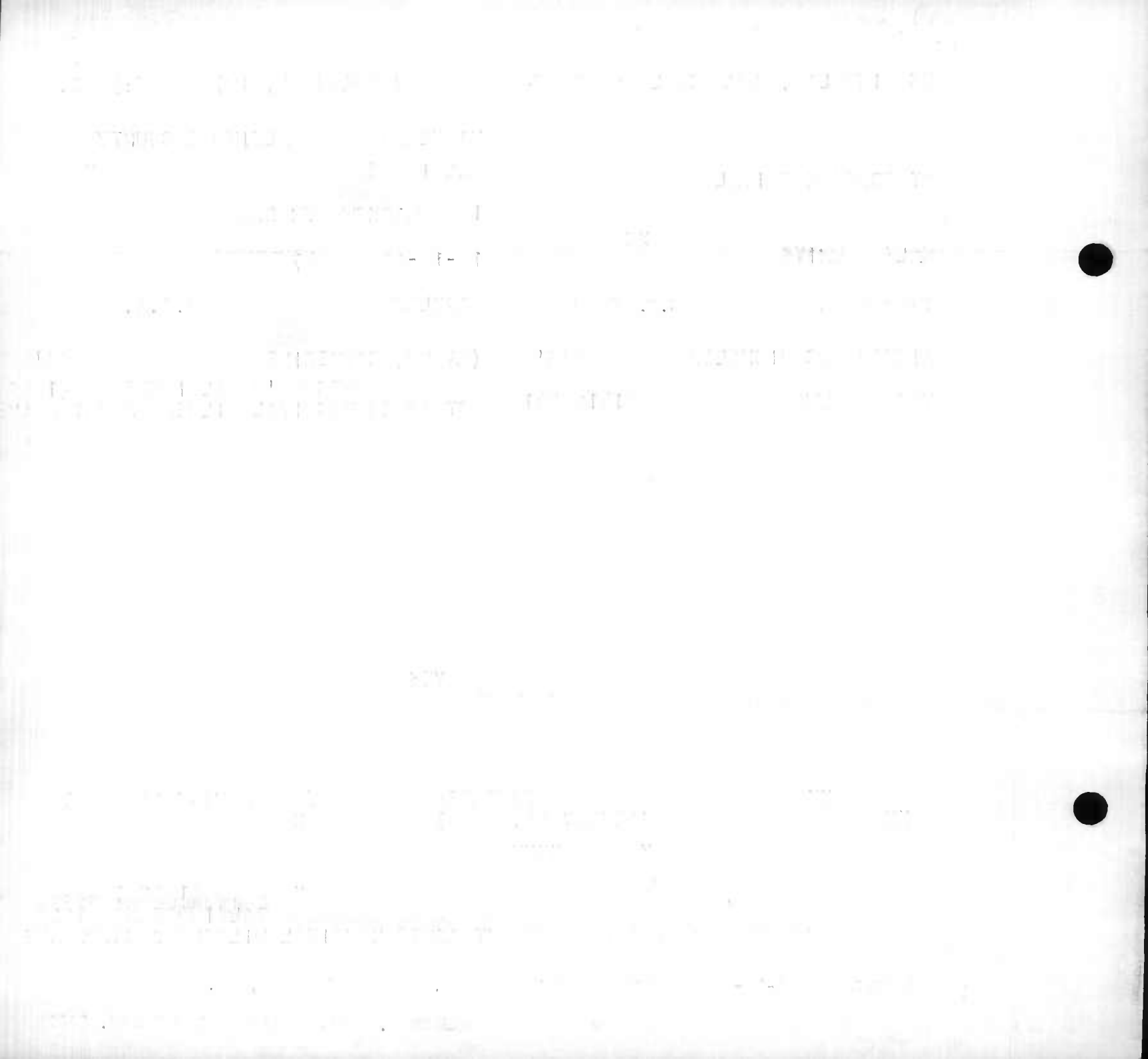
Baltimore City Health Department				REG. NO.	
B-620 70 00880		70 00880		70 00880	
1. NAME OF DECEASED (Type or Print)		CHESTER N. BURRS		2. DATE AND HOUR OF DEATH 1-23-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1048 ROCKHILL AVE.		A. STATE MD.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1048 ROCKHILL AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-95	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE E. BURRS		14. MOTHER'S MAIDEN NAME LOUISE WILSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218126920		17. INFORMANT ANNA M. BURRS 1048 ROCKHILL AVE. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 161.9 I CAUSE OF DEATH Ca. of Carcinoma with metastases - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Permeious Anemia - Coronary.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-4-81 19 to 1-23-70 19, that (I) (we) last saw the deceased alive on 1-22-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry S. Gimble		23B. DATE SIGNED 1-23-70			
23C. PHYSICIAN'S NAME (Type) HARRY S. GIMBLE		23D. ADDRESS 4605 EDMONDSON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-70		24C. NAME of CEMETERY or CREMATORY POPIAR GROVE CEM.	
24D. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD.					
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00881</u>	
BIRTH NO. <u>M-252</u>		70 00881	
1. NAME OF DECEASED <u>XXXXXXXXXXXX, JOHN CARL MC NICHOLAS</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 22, 1970</u> <u>5:30 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>40</u>		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1000 MARKSWORTH ROAD</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-22</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>E.C. ERNST</u>	9. AGE (In years last birthday) <u>47</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD MC NICHOLAS</u>		14. MOTHER'S MAIDEN NAME <u>(PARKS) CATHERINE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>214128441</u>	
17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>		ADDRESS	
18. <u>205.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) <u>Ac. Granulocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 29</u> 19 <u>69</u> to <u>JANUARY 22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>JANUARY 22</u> 19 <u>70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Zaheer Khan</u>		23B. DATE SIGNED <u>01-22-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ZAHKEER KHAN</u>		23D. ADDRESS <u>BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>1-26-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u>	24D. LOCATION <u>BALTIMORE, MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u>		ADDRESS <u>4107 WILKENS AVE. 21229</u>	





# FUNERAL DIRECTOR: IMPORTANT

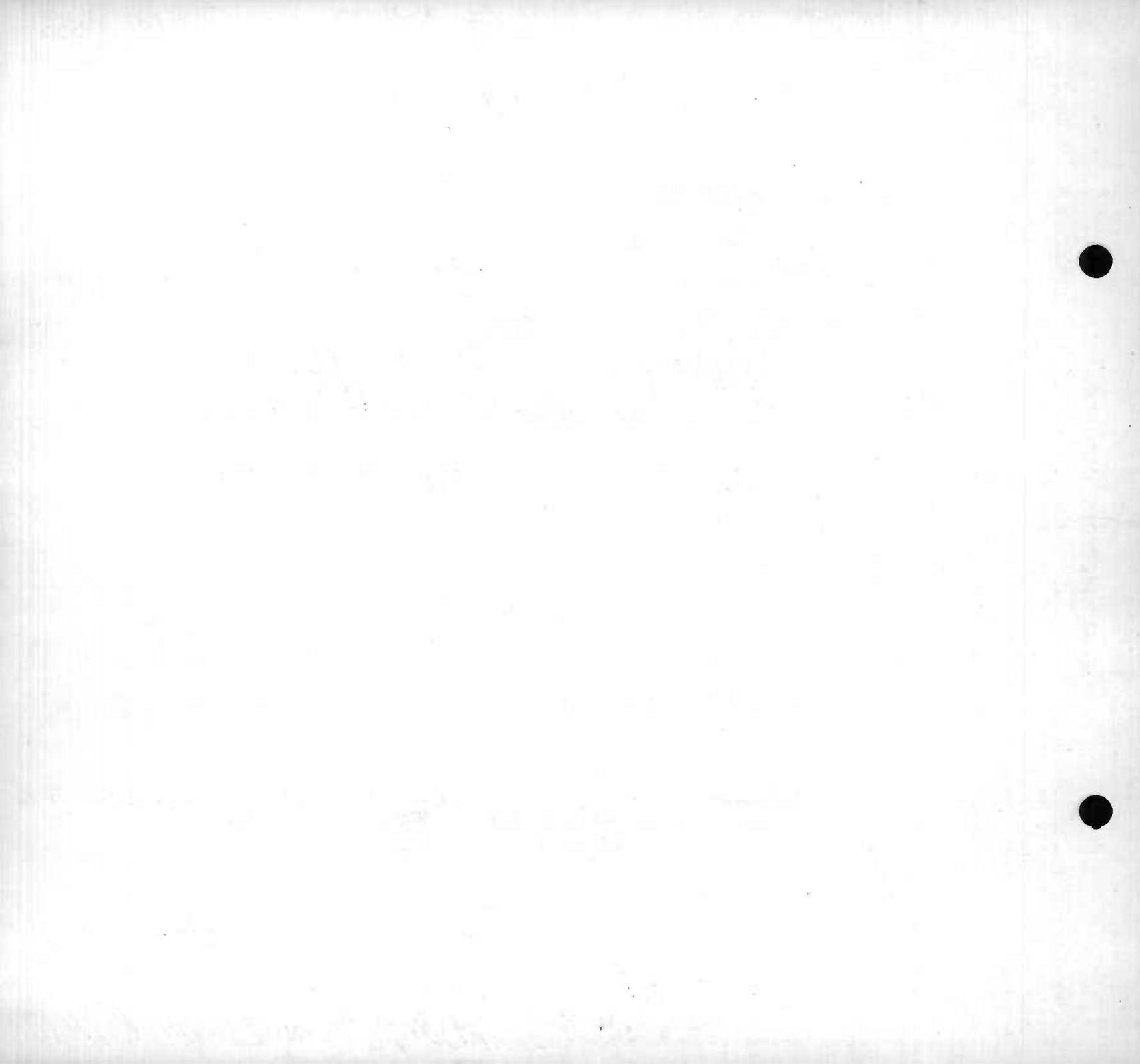
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-512 70 00882		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00882	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George A Snoops		Jan 21 1970 8 30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
90 The Wesley Home		2211 W Rogers Ave		Baltimore	
D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 W Rogers Ave			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 20 1880	89	Purchasing Agent Spice Mfg
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
				Md	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
John V Snoops		Sarah E Hose			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
212 16 0292		The Wesley Home		Same	
18. 153.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		Carcinoma caecum			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
24 Nov 69	Carcinoma caecum	No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 21 November 1969 to 21 January 1970, that (I) (we) last saw the deceased alive on 20 January 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
John W Barnaby		DEGREE		23 Jan 70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John W Barnaby		1652 E Belcher Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	1-24-70	Baltimore Cem	Baltimore Md		
25A. DATE TESTED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				Burgess Funeral Home Baltimore Md	
				Address	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 70 00883	
W-420 70 00883		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Grace Elizabeth Welsh</b>		2. DATE AND HOUR OF DEATH <b>JAN 20 1970</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>005930 Falls Rd</b>		A. STATE <b>Md</b> B. COUNTY <b>2755</b>	
5. SEX <b>Female</b> 6. RACE <b>White</b>		C. CITY OR TOWN <b>Balti</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>5930 Falls Rd</b>	
8. DATE OF BIRTH <b>Mar 21 1901</b> 9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Laura Wehr</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or No) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 487560</b>	
17. INFORMANT <b>Charles J. Giles Welsh</b>		ADDRESS <b>same</b>	
18. <b>200.1 I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <b>Lymphosarcoma</b>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 20 1969</b> to <b>Jan 20 1970</b> , that (I) (we) last saw the deceased alive on <b>Jan 19 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Edward L. Glassman</b>		23B. DATE SIGNED <b>1/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward L. Glassman</b>		23D. ADDRESS <b>4037 Falls Rd. Balt. Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mesdownridge Mem</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co Md</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Burger Funeral Home</b>		ADDRESS <b>Balti Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00884</span>	
BIRTH NO. <span style="float: right;">70 00884</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HARVEY E. PARSONS</b>			2. DATE AND HOUR OF DEATH <b>1/23/70</b> <span style="float: right;">3<sup>50</sup> A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1306</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3414 HICKORY AVE.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/95</b>	9. AGE On years (lost Birthday) <b>75</b> <span style="float: right;">74</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GEAR SHAPER-</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Machinery Mfg</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>JAMES E. PARSONS</b>			14. MOTHER'S MAIDEN NAME <b>FLORENCE STUP.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>22005-5257</b>		17. INFORMANT <b>MRS. FLORENCE B. PARSONS</b>	
				ADDRESS <b>3414 HICKORY AVE.</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b> <b>due to pulmonary emphysema + fibrosis</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardio-vascular disease</b>		
			(C) <b>EC</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/9/70</b> to <b>1/22/70</b> and that (I) (we) lost the deceased on <b>1/22/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anne L. Leddy M.D.</b>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Anne L. Leddy</b>
23D. ADDRESS <b>Union Memorial Hospital Baltimore Maryland</b>			23E. ADDRESS <b>Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>1-26-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Louisa Park Cem</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION <b>Baltimore</b>		24F. LOCATION <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>James E. Leddy</b>		25C. FUNERAL DIRECTOR <b>Burger Funeral Home</b>	
				ADDRESS <b>Baltimore</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		70 00885		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		70 00885	
BIRTH NO.						1. NAME OF DECEASED (Type or Print) <b>MILDRED E. Jones</b>					
2. DATE AND HOUR OF DEATH <b>January 22 1970</b> <b>1:35</b> <b>P.M.</b>						3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>33 THE JOHNS HOPKINS HOSPITAL</b>					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO. CO.</b> <b>5300</b>						5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER <b>229 A. ENGELBERTH RD.</b>						6. SEX <b>FEMALE</b> 7. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>12-5-17</b>						9. AGE (In years last birthday) <b>52</b> 11. Under 1 Yr. Months Days 12. Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>						10B. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>					
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>						12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>SMOLEK</b>						14. MOTHER'S MAIDEN NAME <b>PAULINE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>						16. SOCIAL SECURITY NO. <b>212 18 0585</b>					
17. INFORMANT <b>MAURICE E. JONES</b>						ADDRESS					
18. <b>174X I</b> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma Breast - Metastases 5 years</b>						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bilateral pleural effusions 8 months</b>						(B) DUE TO, OR AS A CONSEQUENCE OF:					
<b>Bilateral pneumothoraces 3 days</b>						(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>Feb 1966</b>						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Radical mastectomy</b>					
20A. AUTOPSY? (Yes or No) <b>No</b>						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					
21C. WHERE DID INJURY OCCUR? <input checked="" type="checkbox"/> (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1/22 1970</b>						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
21F. HOW DID INJURY OCCUR? <b>1</b>											
22. I certify that (I) (this hospital) attended the deceased from <b>1/19</b> <b>1970</b> to <b>1/22</b> <b>1970</b> that (I) <b>(we)</b> lost saw the deceased alive on <b>1/22</b> <b>1970</b> and that (in my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.											
23A. SIGNATURE <b>Leroy M. Parker M.D.</b>						23B. DATE SIGNED <b>1/22/70</b>					
23C. PHYSICIAN'S NAME (Type) <b>LEROY M. PARKER M.D.</b>						23D. ADDRESS <b>Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>						24B. DATE <b>1-26-70</b>					
24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEM.</b>						24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>						25B. NAME OF REGISTRAR <b>E. Valley</b>					
25C. FUNERAL DIRECTOR <b>Harley H. H. - 2334 Jefferson St.</b>						ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70 00886</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00886</u>			
1. NAME OF DECEASED (Type or Print) <u>MAMIE M. PFEIFER</u>				2. DATE AND HOUR OF DEATH <u>1/23/70</u> <u>11/30 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore city hospitals</u> <u>4940 Eastern Avenue, Baltimore, Maryland</u> <u>21224</u>				A. STATE <u>Md.</u> B. COUNTY <u>2605</u>							
				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>363 Fulcroft st.</u> <u>21224</u>							
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-6-06</u>		9. AGE in years (last birthday) <u>63 y.</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Benjamin PFEIFER</u>				14. MOTHER'S MAIDEN NAME <u>Edith ROMER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218 18 7493</u>				17. INFORMANT <u>Records: BCH-4940 Eastern Avenue</u> <u>21224</u>			
18. <u>430.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemo-</u> <u>rrhage secondary to ruptured</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Basilar artery aneurysm</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>1/21</u> 19 <u>70</u> to <u>1/23</u> 19 <u>70</u> that (X) (we) last saw the deceased alive on <u>1/23</u> 19 <u>70</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>MEHDI SARKARATI M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1/23/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>MEHDI SARKARATI</u>				23D. ADDRESS <u>Baltimore city Ho Sp.</u> <u>21224</u> <u>4940 Eastern Avenue, Baltimore, Md.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>1-27-70</u>				24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cem.</u>			
24D. LOCATION (City, town, or county) <u>BALTO., Md.</u>				(State) <u></u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Sackey</u>				25C. FUNERAL DIRECTOR <u>Charles W. Allen</u> <u>2334 Jefferson St.</u>			
25D. ADDRESS <u></u>											

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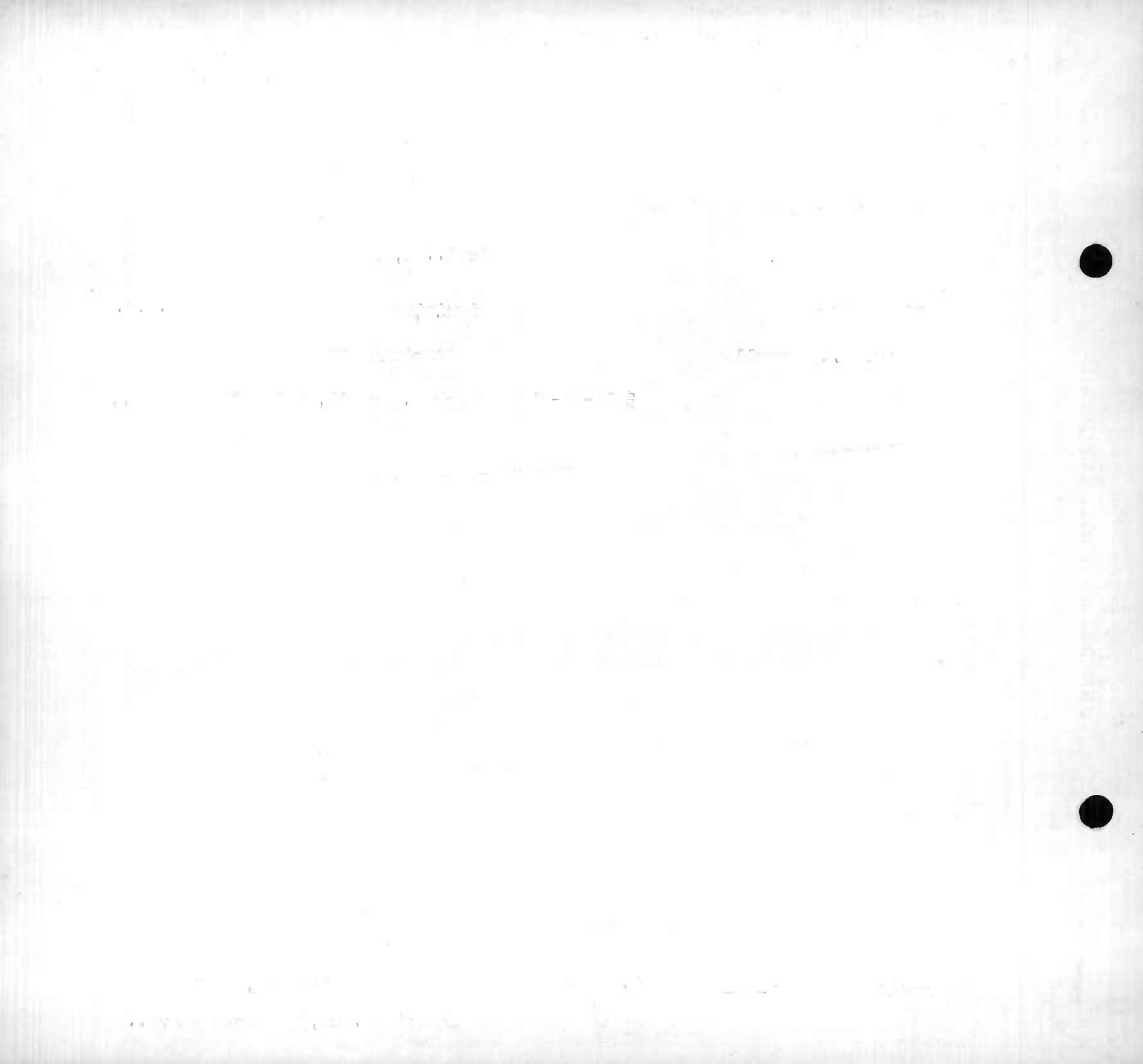
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70 00887</b></p>	
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>DOSWELL RICHARD B.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>1-23-1970 8:20 A.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL</b> <b>730 ASHBURTON ST. BALTIMORE MD 21216</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>1506</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3410 WALBROOK AVENUE</b></p>	
<p><b>5. SEX</b> <b>MALE</b> <b>6. RACE</b> <b>NEGRO</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>Sept. 12, 1919</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>50</b> <b>If Under 1 Yr. Months: Days: Hours: Min.</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cook &amp; Baker</b></p>	<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>
<p><b>13. FATHER'S NAME</b> <b>Edward W., Doswell</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Elizebeth Wilks</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>	<p><b>16. SOCIAL SECURITY NO.</b> <b>213-03-3167</b></p>	<p><b>17. INFORMANT</b> <b>James I. Doswell</b> <b>ADDRESS</b> <b>3401 Walbrook Ave..</b></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>320.8 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>(A) IMMEDIATE CAUSE</b> <b>? MENINGITIS</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) STAPHYLOCOCCAL BACTEREMIA</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>			
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from 1-15-1970 to 1-23-1970, that (I) (we) last saw the deceased alive on 1-23-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>[Signature]</i> <b>M.B.B.S.</b></p>	<p><b>23B. DATE SIGNED</b> <b>1-23-1970</b></p>	<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>PREM LAL. M.B.B.S.</b></p>	
<p><b>23D. ADDRESS</b> <b>LUTHERAN HOSPITAL</b> <b>730 ASHBURTON ST. BALTIMORE MD 21216</b></p>		<p><b>24. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>	
<p><b>24A. DATE</b> <b>1-29-70</b></p>	<p><b>24B. NAME OF CEMETERY or CREMATORY</b> <b>Mt. Auburn</b></p>	<p><b>24C. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 26 1970</b></p>	<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b></p>	<p><b>25C. FUNERAL DIRECTOR</b> <b>Kenneth H. Law</b> <b>ADDRESS</b> <b>3503 Berwyn Ave..</b></p>	



7-432 70 00888

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00888

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>POWELL E. FLETCHER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME AND HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 23, 1970 11:55 P.</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>401</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>7-15--1905</b>		10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.</b>		12. CITIZEN OF <b>U.S.A.</b>	E. STREET AND NUMBER <b>Marine Hotel, Pratt and Gay Streets</b>
13. FATHER'S NAME <b>Rodney Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Missouria Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-1855</b>	17. INFORMANT <b>Evelyn Smith, 774 W. Fayette St.</b>
18. CAUSE OF DEATH <b>Craniocerebral Injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E928 X</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <b>Factory</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Terminal Warehouse 401</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1-19-70 Unk. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject walked into folk lift</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/24/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-28-1970</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	25C. FUNERAL DIRECTOR <b>Kenneth H. Law, 3503 Berwyn Ave 21207</b>

WILSON & WILSON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530 70 00889 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00889	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BENNETT, ISIAH		11/22/70 7 30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
PLACE NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Baltimore City Hospitals			Maryland		
4940 Eastern Avenue, Baltimore, Md. 21224			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3404 Hayward Avenue 21215		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	Negro		3-5-1924	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER		FERTILIZER FACTORY		SOUTH CAROLINA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JACK BENNETT			U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
yes W W 2			250-28-1565		Record: BCH-4940 Eastern Avenue 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Terminal metastatic		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Laryngeal Ca, progressed then gangrene of lower extremities		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			+ possible broncho pneumonia		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
progressed dry gangrene of lower extremities					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 -				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 1/10 1970 to 1/22 1970					
that (X) (we) last saw the deceased alive on 1/10 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Meheli Sarkarati, M.D.				1/22/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Meheli Sarkarati, M.D.				4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1/26/70		National cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 26 1970		Robert E. Taylor, M.D.		1206 W North Ave	

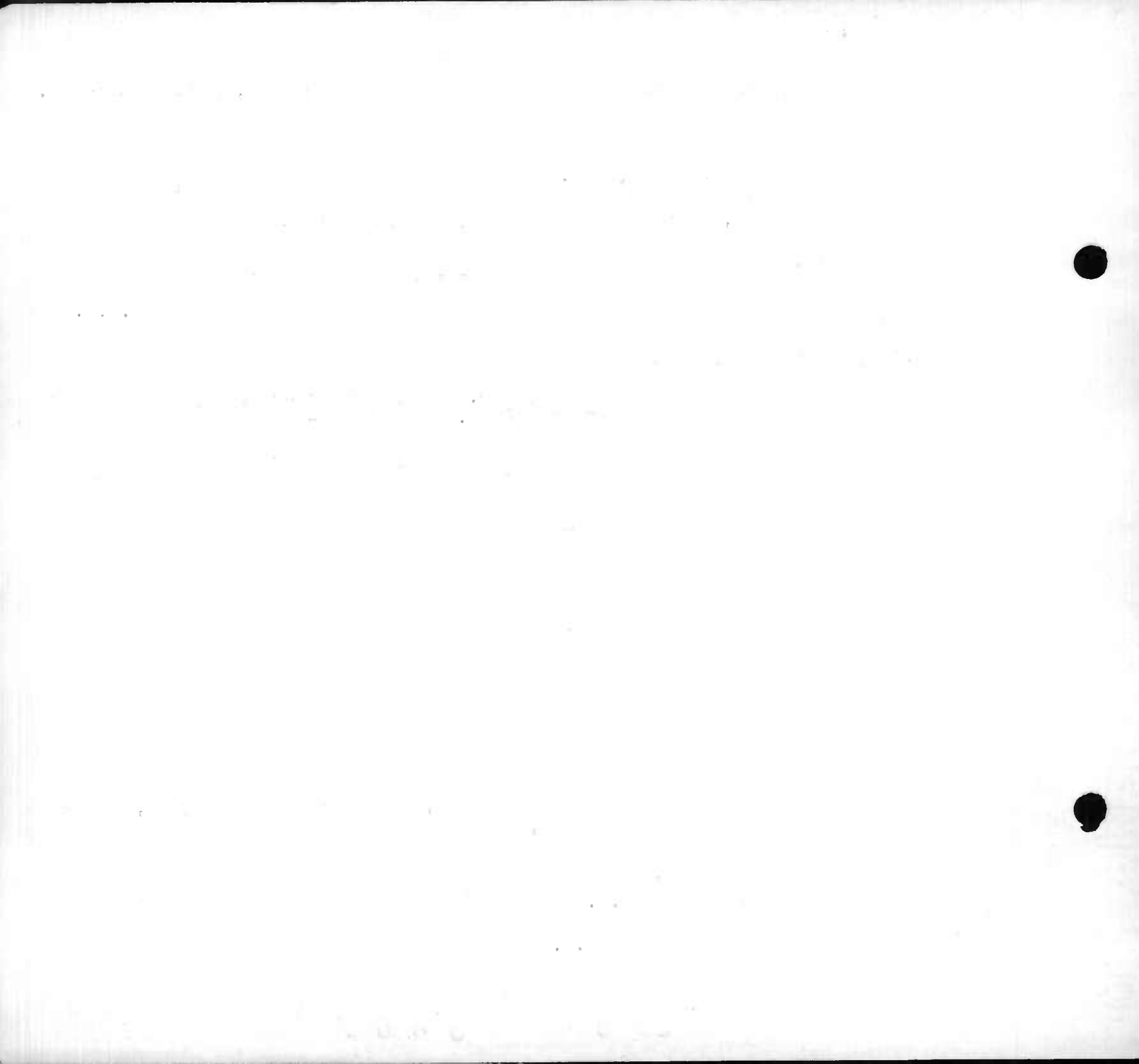




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-363		70 00890		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 00890	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lonnie Stewart</b>				2. DATE AND HOUR OF DEATH <b>January 15, 1970 4:10 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>				C. CITY OR TOWN <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-97</b>		9. AGE (In years lost birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>HARRY STEWART</b>				14. MOTHER'S MAIDEN NAME <b>STEWART</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-01-2425</b>		17. INFORMANT <b>Mr. Hilliary Leach-nephew 3518 Caton Avenue</b> <b>Mrs. Sarah Leach-niece 3518 Caton Avenue</b>					
18. <b>451.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>PULMONARY EMBOLI</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASHD, PULMONARY EMPHYSEMA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULMONARY EMBOLI</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>PHLEBOTOMOSIS, LEFT</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b> <b>DAYS-WKS</b> <b>YRS</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>January 5, 1970</b> to <b>January 15, 1970</b> that (I) (we) last saw the deceased alive on <b>January 15, 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Elyah Gunden M.D.</b>				23B. DATE SIGNED <b>1/16/70</b>				23C. PHYSICIAN'S NAME (Type) <b>Elyah Gunden M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Westport Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Becc 201-7000</b>		25C. FUNERAL DIRECTOR <b>Chas J 1922 Edm...</b>		ADDRESS			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

70-00069

REG. NO.

70 00891

1. NAME OF DECEASED (Type or Print) <u>Debra ANN CALLAHAN</u>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <u>1</u> Day <u>21</u> Year <u>70</u> Hour <u>2:00</u> p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00</u> <u>Wooded Area Georgetown &amp; Parksley</u>		3. DATE PRONOUNCED DEAD Month <u>January</u> Day <u>21</u> Year <u>1970</u> Hour <u>2:00</u> p.m.	
6. SEX <u>Female</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>Jan. 1, 1970</u>		10. AGE (in years lost birthday) <u>20</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>**</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>**</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) <u>**</u>		17. SOCIAL SECURITY NO. <u>**</u>	
18. INFORMANT <u>Mrs. Alice Elliott</u> ADDRESS <u>same as # 4</u>		15. MOTHER'S MAIDEN NAME <u>Alice (Elliott)</u>	
19. <u>E 763 X</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Asphyxia due to Smothering</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>YES</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <u>1900 Maryland Avenue</u>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>Jan. 18-19, 1970</u> Unk.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Smothered</u> <u>12-05</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 26, 1970</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jolley, M.D.</u>	
25C. FUNERAL DIRECTOR <u>McCully</u>		ADDRESS <u>136 E. Fort Ave. Balto. Md. 21230</u>	

Letter from M.E.'s office

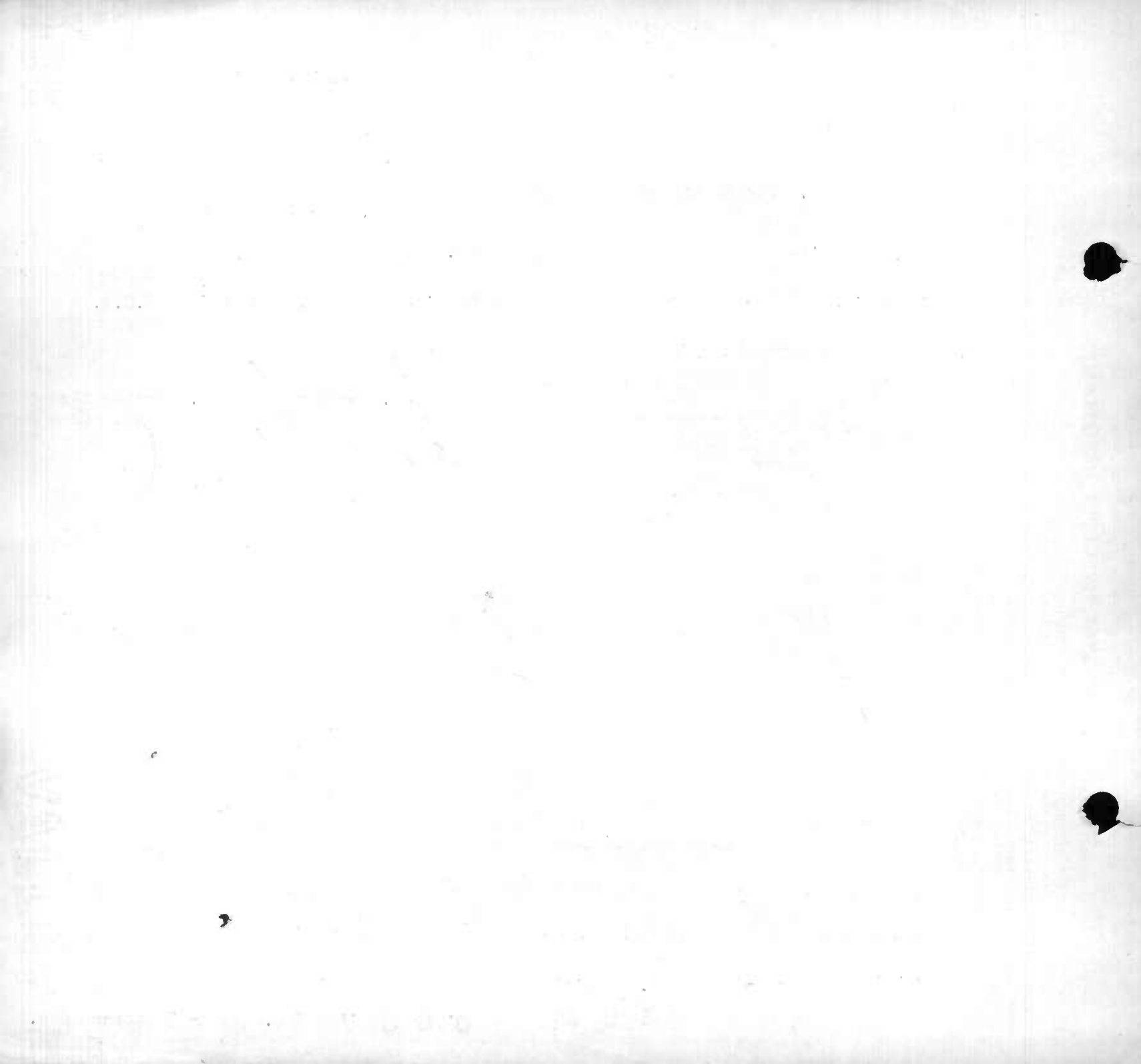
2-5-70 M.H.

*Q. 11/1/70*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00892				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00892	
1. NAME OF DECEASED (Type or Print) <b>EVA GARDNER</b>				2. DATE AND HOUR OF DEATH <b>January 25, 1970</b> <b>4 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3610 E. Fayette Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2653</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3610 E. Fayette Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1890</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fernand Spath</b>				14. MOTHER'S MAIDEN NAME <b>Magdalene</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles C. Gardner</b>		ADDRESS <b>3610 E. Fayette Street</b>	
18. <b>794X + 151.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Senility</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Adenocarcinoma - stomach</b>						<b>1965</b>	
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 9, 1959</b> to <b>Jan. 25, 1970</b> , that (I) (we) last saw the deceased alive on <b>Jan. 13, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sigmund R. Nowak M.D.</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Jan. 26, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>SIGMUND R. NOWAK M.D.</b> DEGREE				23D. ADDRESS <b>408 S. PATTERSON PARK AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-1970</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21231</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>0118 Zeller Inc.</b> ADDRESS <b>1901-07 Eastern Ave.</b>			



1  
A-522

BALTIMORE CITY HEALTH DEPARTMENT

70 00893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00893

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES F. ANUSZEWSKI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>413 S. Collington Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 23, 1970 5:30 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>105</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sept. 23, 1900</b>	10. AGE (In years last birthday) <b>69</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Anuszewski</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Antonette Wienckowski</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11-14-42 9-21-43</b>		17. SOCIAL SECURITY NO. <b>212-0913917</b>	
18. INFORMANT <b>Mrs Josephine Myers</b>		ADDRESS <b>413 S. Collington Ave.</b>	
19. <b>011.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/24/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-27-1970</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Sabe, M.D.</b>	25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	ADDRESS <b>1901-07 Eastern Ave.</b>





ACADEMY RECORD



VALLEY BUSH CO



BIRTH NO.		1. NAME OF DECEASED (Type or Print) LULA MANNING		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 22 70 12:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 22, 1970 12:40 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1512	
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH May 1, 1896		10. AGE (In years lost birthday) 73	E. STREET AND NUMBER 3722 Reisterstown Rd.		
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF U.S.A.	13. FATHER'S NAME Sam Winbush		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Nymphus Manning 3722 Reisterstown Rd.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.2 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/23/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/70		24C. NAME OF CEMETERY or CREMATORY Odd Fellows Cem.	
24D. LOCATION (City, town, or county) (State) Williamston, N.C.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Kelson F. H. 1348 N. Calhoun St.			

BASE SCOTT  
VILLEY PAPER CO

106A

*[Faint signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 00895	
B-550				70 00895	
CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CLEVE Bowman, Sr.</b>		2. DATE AND HOUR OF DEATH <b>1/23/70</b> <b>8:15 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1901</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1509 W. Fairmount Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/22/97</b>	9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Sumpter, South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN (John Bowman)</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-87-3238</b>	
17. INFORMANT <b>Mrs. Willie Bowman</b>		ADDRESS <b>1509 W. Fairmount</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>HEUD</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>metastatic Adenocarcinoma to lungs</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>15 days</b>	
		(C) <b>Osteoarthritis</b>		<b>~ 3 yrs.</b>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Probable Bicuspid Aortic Heart Disease ~ 3 yrs.</b>			
19A. DATE OF OPERATION <b>1/8/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Lung Neoplasm</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> 19 <b>69</b> to <b>1/23</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/22</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles L. Cromwell</b>				23B. DATE SIGNED <b>1/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles L. Cromwell, M.D.</b>		23D. ADDRESS <b>University of Maryland Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>H. Auburn Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>Blanton Dye</b>			
25A. DATE RECD BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Blanton Dye</b>		25C. FUNERAL DIRECTOR <b>Dyett F.H. 1701 Laurens</b>	



1. NAME OF DECEASED (Type or Print) <b>JOHN GALBREATH, JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 24, 1970 4:15 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-12</b>	
9. DATE OF BIRTH <b>March 26, 1969</b>		10. AGE (in years lost birthday) <b>10</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>XXXXXX Galbreath, John E.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
15. MOTHER'S MAIDEN NAME <b>Eloise Galbreath</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>-0-</b>		18. INFORMANT <b>Mr. John E. Galbreath</b>	
19. ADDRESS <b>2902 Springhill Avenue</b>			

19. <b>E 812.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cranio-cerebral Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2500 blk. Towanda at intersection of O'Calla</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1-24-70 4:00 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision</b>

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Ronald N. Kornblum* M.D.  
 EXAMINER'S NAME (Type): **Ronald N. Kornblum, M.D.**

CHIEF MEDICAL EXAMINER ☐  
 ASSISTANT MEDICAL EXAMINER ☒  
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: **1/25/70**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-28-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	ADDRESS <b>1701 Laurens Street</b>

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*Paul Walker*

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00897</u>	
B-453		70 00897		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Beraldine E. Bland</u>		2. DATE AND HOUR OF DEATH <u>1/22/70 10:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1608</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>733 Grantley Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/37</u>	9. AGE (in years last birthday) <u>32</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rocky Mount, N.C.</u>	
13. FATHER'S NAME <u>Jesse Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Hedgepeth</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-34-3132</u>		17. INFORMANT ADDRESS <u>Mr. Ralph B. Bland 733 Grantley Street</u>	
18. <u>446.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PRESUMED COLLAGEN VASCULAR DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> 19 <u>70</u> to <u>1/22</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James L. Bolen M.D.</u>				23B. DATE SIGNED <u>1/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>James L. Bolen, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTON &amp; DYER</u>		25D. ADDRESS <u>F.H. 1701 Laurens Street</u>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRED CUTLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 22 70 6:00 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 22 70 6:00 p. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-1-1903</b>		10. AGE (In years lost birthday) <b>66</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Beth-Steel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>213-07-1222</b>	
18. INFORMANT <b>Mrs. Elizabeth Sheppard</b>		ADDRESS <b>2302 Braddish Avenue</b>	
19. CAUSE OF DEATH <b>319.28-185X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Prostate carcinoma Fracture of right hip</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural cause</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-27-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>	25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	ADDRESS <b>1701 Laurens Street</b>



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VALLEY PARK

THE CHURCH

ACADEMIC

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
BIRTH NO. 70 00899		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>THERESA JACKSON</b>		2. DATE AND HOUR OF DEATH <b>Jan 22 / 1970</b> 11:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <b>STATE Md., B. COUNTY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY Hosps.</b>		C. CITY OR TOWN <b>Baltimore Md.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 Eastern Ave 21224</b>		E. STREET AND NUMBER <b>1506 N. Register St. 21213</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-26</b>	9. AGE (In years last birthday) <b>43 y.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Run Machine</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steeltn Co</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>William H. Boone</b>		14. MOTHER'S MAIDEN NAME <b>Marie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>912-99-5842</b>		17. INFORMANT <b>4940 Eastern Ave</b> <b>BCH Records: Baltimore, Maryland 21224</b>	
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Terminal metastatic</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ca of cancer (Froze pelvis), dehydration due to the small bowel fistula</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intractable pain</b>		20A. AUTOPSY (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec 1</b> 19 <b>69</b> to <b>Jan 22</b> 19 <b>70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/22</b> 19 <b>70</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mehdi Sarkarati M.D.</b>				23B. DATE SIGNED <b>1/22/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>MEHDI SARKARATI M.D.</b>				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224 BALTIMORE CITY HOSPITALS</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-27-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto National Cem Balto</b>	
24D. LOCATION <b>Md</b>		24E. NAME OF REGISTRAR <b>John E. Sanders</b>		24F. FUNERAL DIRECTOR <b>John E. Sanders</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>John E. Sanders</b>		25C. FUNERAL DIRECTOR <b>John E. Sanders</b>	

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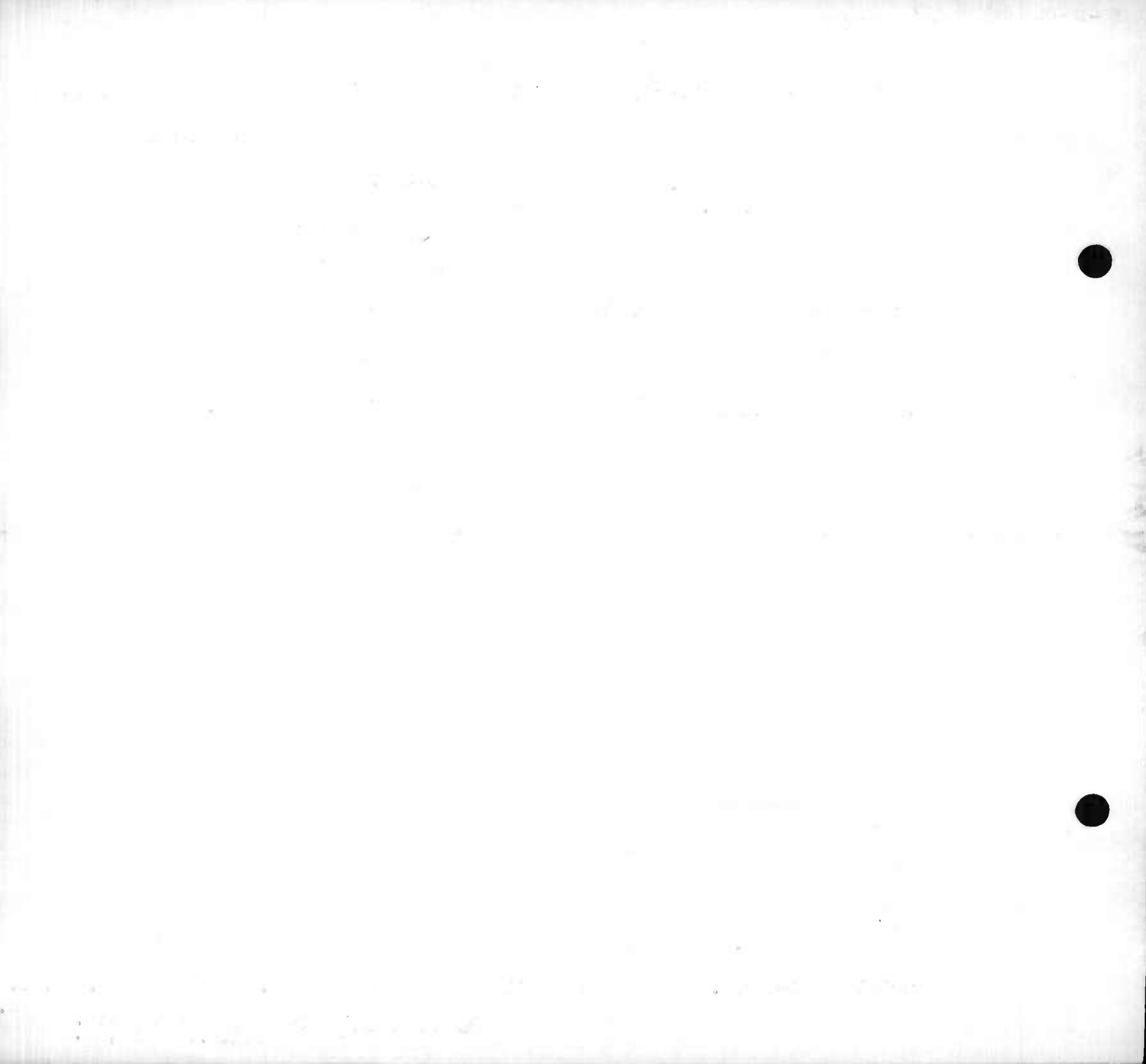
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

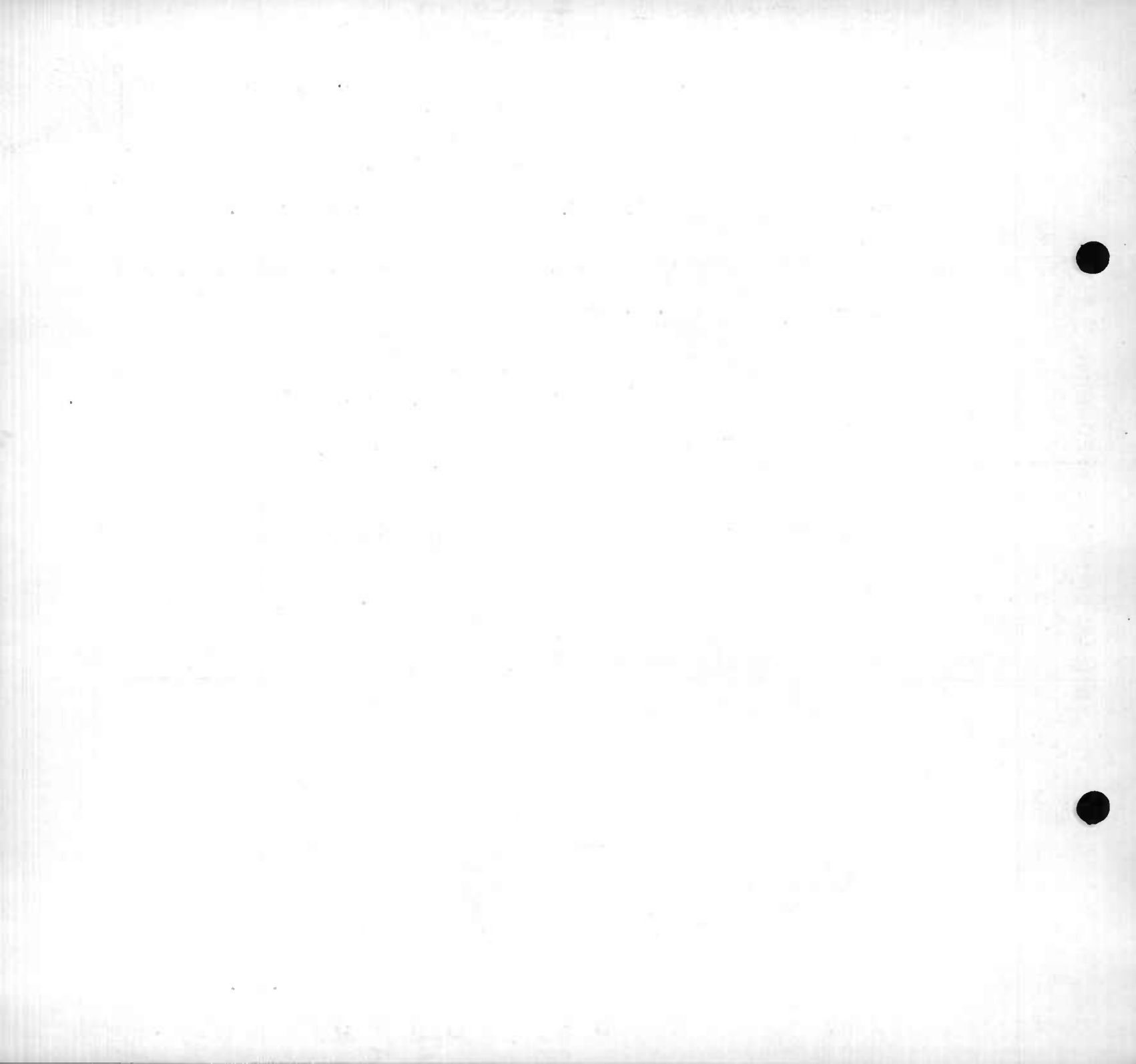
BIRTH NO. <u>R-220</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00900</u>	
1. NAME OF DECEASED (Type or Print) <u>Anna RUSZKIEWICZ</u>			2. DATE AND HOUR OF DEATH <u>1/22/70</u> <u>12:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> 4940 Eastern Ave. Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Eastpoint</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>415 Scarsdale Rd. 21224</u> <u>805</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-95</u>	9. AGE (In years last birthday) <u>74</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Michael Nestorowski</u>			14. MOTHER'S MAIDEN NAME <u>Catherine</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>169-03-1040</u>		17. INFORMANT <u>BCH Records:</u> ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Stroke</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>70</u> to <u>1/22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack D. Mc Cue M.D.</u>			23B. DATE SIGNED <u>1/22/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Jack D. Mc Cue D.R.R.</u>			23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave, Baltimore, Md. 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-24-70.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	
24D. LOCATION (City, town, or county) (State) <u>Kenwood Av. &amp; Trumps Mill Rd., Ba. Co.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Ziller</u> ADDRESS <u>6224 Eastern Ave. Balto., 21224, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 00901
C-625		70 00901		
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Joseph Z. Chrisman		Jan. 22, 1970 12 45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
90 House in Pines 5837 Belair Rd.		Maryland Baltimore CO. 5300		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		2120 Westchester Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11 14 1883	86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Sergeant-Retired		U. S. Army		Kentucky
12. CITIZEN OF WHAT COUNTRY?		U S A		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Unknown Chrisman		Unknown Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes # 1				Paul E. Chrisman 2120 Westchester Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
436.0 V 250.9		Multiple Strokes		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) Arteriosclerotic Vascular Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		
II		(C) Diabetes mellitus, maturity onset.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Postural Hypertension, Chronic Brain Syndrome		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from 1/21/1970 to 1/22/1970, that (I) (me) last saw the deceased alive on 1/21/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Albert D. Bradley				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Cremation		1 27 70		Loudon Park
				Balto. Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JAN 26 1970		Robert E. Gully		130 E. Fort Ave





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00902</u>
G-635 70 00902		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>ALBERT W. GARDNER</u>		
2. DATE AND HOUR OF DEATH <u>9:55 pm 1/22/70</u>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>MD</u> B. COUNTY _____		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>3500 CHESTNUT AVE</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD WORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>4/16/03</u>
13. FATHER'S NAME <u>William Laird Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Francis Taylor</u>		9. AGE (In years last birthday) <u>67</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-05-6858</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
17. INFORMANT <u>CHARLES F. GARDNER</u>		ADDRESS <u>Arundel Beach Rd. Severna Pk. Md. Bx. 349 Rt. 1</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary edema, severe, bil.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>O.Y.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>1/22/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ronald W. Geckler</u> MD		23B. DATE SIGNED <u>1/22/70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Ronald W. Geckler, M.D.</u>		23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Huber</u>		25C. FUNERAL DIRECTOR <u>Adon Donovan</u>		
25D. ADDRESS <u>3818 Roland Ave.</u>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

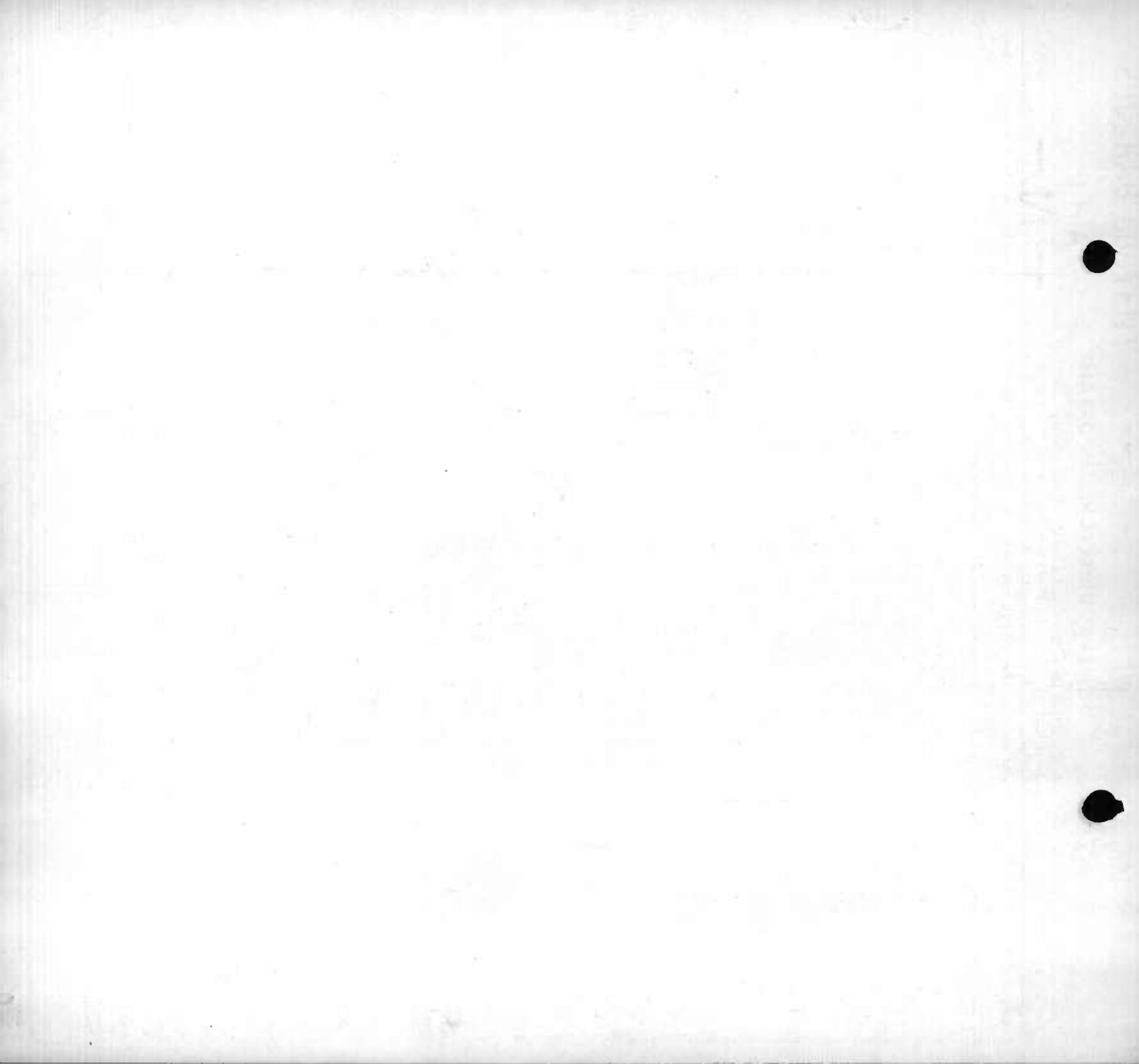
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 00903</span>	
5-160		70 00903		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">E.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1-23-70</span> <span style="float: right;">3:00 P.M.</span>			
<span style="font-size: 1.2em;">Mae Shaffer</span>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <span style="font-size: 1.2em;">BOLTON HILL NURSING &amp; CONVALESCENT CENTER</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1207</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>		6. RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">6-12-1917</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">52</span>		10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Va.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">Samuel Shaffer Webster</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Seitz</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">?</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Joseph E. Shaffer-425 W. 24th St.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CA / bladder with yeast</span>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Hydromyphrosis -</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">6/69</span>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">Ventral Hernia at navel / breast</span>					
21A. DATE OF OPERATION <span style="font-size: 1.2em;">1/22/70</span>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No)	
21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21E. HOW DID INJURY OCCUR?	
21F. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/22/70</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">1/23/70</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">1/23</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Allan H. Macht</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/24/70</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ALLAN H. MACHT MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">2 E Real St Balt MD 21202</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1/27/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National Cem.</span>	
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Baltimore</span>		24E. STATE <span style="font-size: 1.2em;">Md.</span>			
25A. DATE RECEIVED BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 26 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Ann Donovan</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">3818 Roland Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

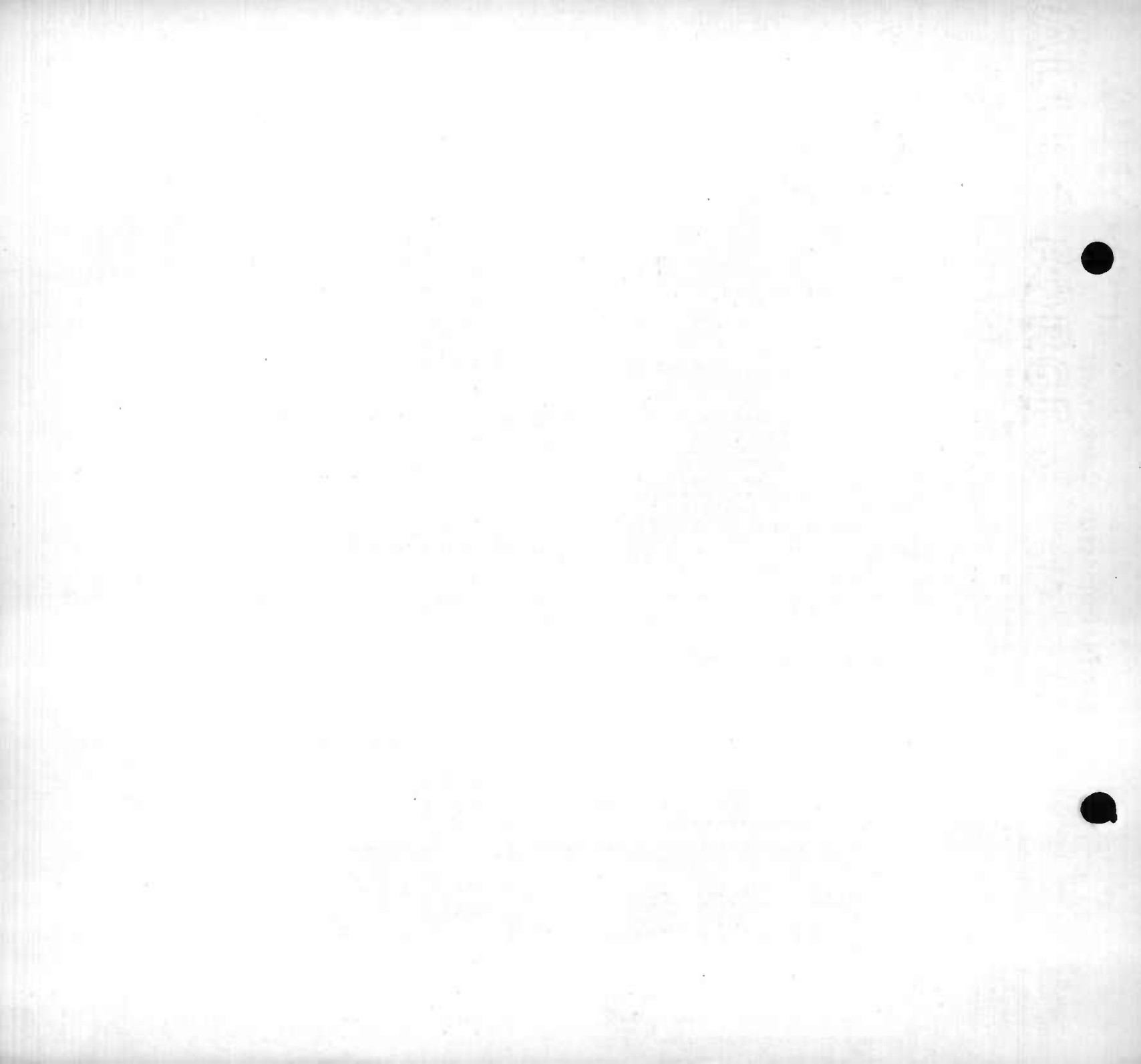
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00904</span>	
BIRTH NO. <span style="float: right;">B-210</span>		70 00904		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Ella C Buschoff</i>		2. DATE AND HOUR OF DEATH <i>1-22-70</i>		8 <sup>45</sup> / <sub>A</sub> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE <i>Md</i> B. COUNTY <i>1306</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House of the Pines</i> <i>90 5837 Belair Road</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>34 57 Hickory Ave</i>		5. SEX <i>F</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-14-88</i> 9. AGE (In years lost birthday) <i>81</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>house wife</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Lloyd</i>		14. MOTHER'S MAIDEN NAME <i>Layfield</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-18-9774A</i>		17. INFORMANT <i>Conrad Buschoff</i>	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intestinal Congestion Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>2 days</i>			
		(C) <i>Arteriosclerotic Cardiovascular Disease</i> <i>Old Myocardial Infarction, multiple Right Hemiplegia</i>		<i>-</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>5/23/1969</i> to <i>1/22/1970</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>1/21/1970</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.		23A. SIGNATURE <i>Albus B Bradley</i>		23B. DATE SIGNED <i>1/24/70</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR <i>Frank A Serty</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-26-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>	
25C. ADDRESS <i>814 N 36th St</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 70 00905				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00905	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Mattie F Barrett</i>		2. DATE AND HOUR OF DEATH <i>January 22-70</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>1307</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>846 W 36th St.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>846 W 36th St.</i>				5. SEX <i>M F</i> 6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-11-1902</i>				9. AGE (In years last birthday) <i>67</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <i>Eldridge F. Alwell</i>		14. MOTHER'S MAIDEN NAME <i>McKenney</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-12-5965</i>		17. INFORMANT <i>Frank C Barrett</i>	
18. ADDRESS <i>846 W 36th St</i>				18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<i>Sudden</i>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>diabetes</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-7</i> <i>1965</i> to <i>1-22</i> <i>1970</i> , that (I) (we) lost the deceased on <i>1-22</i> <i>1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Reuben Hoffman, M.D.</i>				23B. DATE SIGNED <i>1-23-70</i>		23C. PHYSICIAN'S NAME (Type) <i>REUBEN HOFFMAN, M.D.</i>	
23D. ADDRESS <i>846 W 36th St. Baltimore, Md.</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-26-70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Garden of Faith</i>				24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>				25B. NAME OF REGISTRAR <i>Reuben Hoffman</i>		25C. FUNERAL DIRECTOR <i>Frank H. Seitz</i>	
25D. ADDRESS <i>814 W 36th St</i>							





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-260 70 00906		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00906	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OSSRY ANNA		1/23/1970 3:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
			B. COUNTY		
SINAI HOSPITAL OF BALTIMORE			Maryland Baltimore Co.		5300
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6737 Towbrook Rd.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/19/88	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		own home		Russia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry Klaff			Hannah Shuman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		213-48-5382		Mrs. Harry Jacobs	
				130 Spa View Ave. Annapolis, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
2. ANTECEDENT CAUSES			Acute Myoc. Infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ASCVD.		
			(C) Diabetes Mellitus.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 1/16/70 to 1/23/70 that (I) (we) last saw the deceased alive on 1/23/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			M.D. DEGREE		23B. DATE SIGNED
ANDREAS A. PETAS			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		1/23/70
			23D. ADDRESS		
SINAI HOSPITAL OF BALTIMORE.					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	1/25/70	Kneseth Israel Cemetery		Annapolis A.A. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 26 1970		V. E. Taylor, R.D.O.		Hopping Funeral Home - Annapolis, Md.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-652 70 00907				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00907	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Willie Mae Franklin</i>		2. DATE AND HOUR OF DEATH <i>1-23-1970 3:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2608</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3721 Claremont Ave 21224</i>			
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-21-1898</i>	9. AGE (in years last birthday) <i>71</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Rubin R Martin</i>				14. MOTHER'S MAIDEN NAME <i>Morning Walters</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no no</i>		16. SOCIAL SECURITY NO. <i>213 10 00370</i>		17. INFORMANT ADDRESS <i>Mrs Rayan Danko 3721 Claremont Ave 24</i>			
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>ASCENDING Duodenal Mollities pneumoniae Bronchopneumoniae Pyelonephritis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-30-1969</i> to <i>1-23-1970</i> that (I) <del>we</del> last saw the deceased alive on <i>1-23-1970</i> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) <del>did not</del> view the body after death.							
23A. SIGNATURE <i>H. MAKIPOU</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>HOUSHANG-MAKIPOU</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 26 1970</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1970</i>		25B. NAME OF REGISTRAR <i>Robert J. Kelly</i>		25C. FUNERAL DIRECTOR <i>Thomas J. Kelly, Inc</i>		ADDRESS <i>1600 Hollins 23</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 00908</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">70 00908</span>	
1. NAME OF DECEASED (Type or Print) <b>Joseph C. Smallwood</b>			2. DATE AND HOUR OF DEATH <b>Jan 21, 1970 1:32<sup>PM</sup></b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>26-36</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>6604 Gary Avenue</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1907</b>	9. AGE (in years lost birthday) <b>62</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	11. BIRTHPLACE (State or foreign country) <b>Sunshine Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Joseph Smallwood</b>			14. MOTHER'S MAIDEN NAME <b>Eva Downs</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-10-6629</b>	17. INFORMANT ADDRESS <b>Myrtle Smallwood 6604 Gary Avenue</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiopulmonary Arrest</b> (B) Prob. Myocard. infarction (C) Atherosclerotic Cardiovascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 21, 1970</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robt N. Schumacher M.D.</b>			23B. DATE SIGNED <b>Jan 21, 1970</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
<b>Burial I-24-70 Oak Lawn Cemetery</b>			<b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Nader</b>		25C. FUNERAL DIRECTOR <b>WALTER DABROWSKI</b>	
				ADDRESS <b>1005 DUNDALK AVENUE</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 BIRTH NO. 70 00909		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 00909	
M.E. CASE NO.		1. NAME OF DECEASED Charles Thomas Mr. Charles Thomas		2. DATE AND HOUR OF DEATH 1-23-70 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore 5300 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Edgemore D. STREET ADDRESS (If rural, give location) 2618 Brannan Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-4-93	9. AGE (In years, lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Millwright Foreman		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Balto Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Max Thomas		14. MOTHER'S MAIDEN NAME Olga ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-7419		17. INFORMANT Mrs. Emma Thomas, 2618 Brannan Ave. Balto. Md. 21219 Wife in admission	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 441.2 I Retropneumothorax hemorrhagic CAUSE OF DEATH (A) Cardiovascular shock DUE TO Rupture of abdominal aortic aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCV (B) Cardiac arrest DUE TO ASCV (C) ASCV		INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 hrs 75			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ac. bronchitis; pulmonary embolism					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 22 1970 to Jan 23 1970, that (I) (we) last saw the deceased alive on Jan 23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. William Schmidt M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED Jan 23, 1970	
23C. PHYSICIAN'S NAME (Type) R. William Schmidt				23D. ADDRESS Maryland General Hospital, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/70		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1970		24F. NAME OF REGISTRAR Robert E. Faiberg, M.D.	
24G. FUNERAL DIRECTOR John V. Duda		24H. ADDRESS 7922 Wise Ave. Dundalk, Md.			

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PH-70-612



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

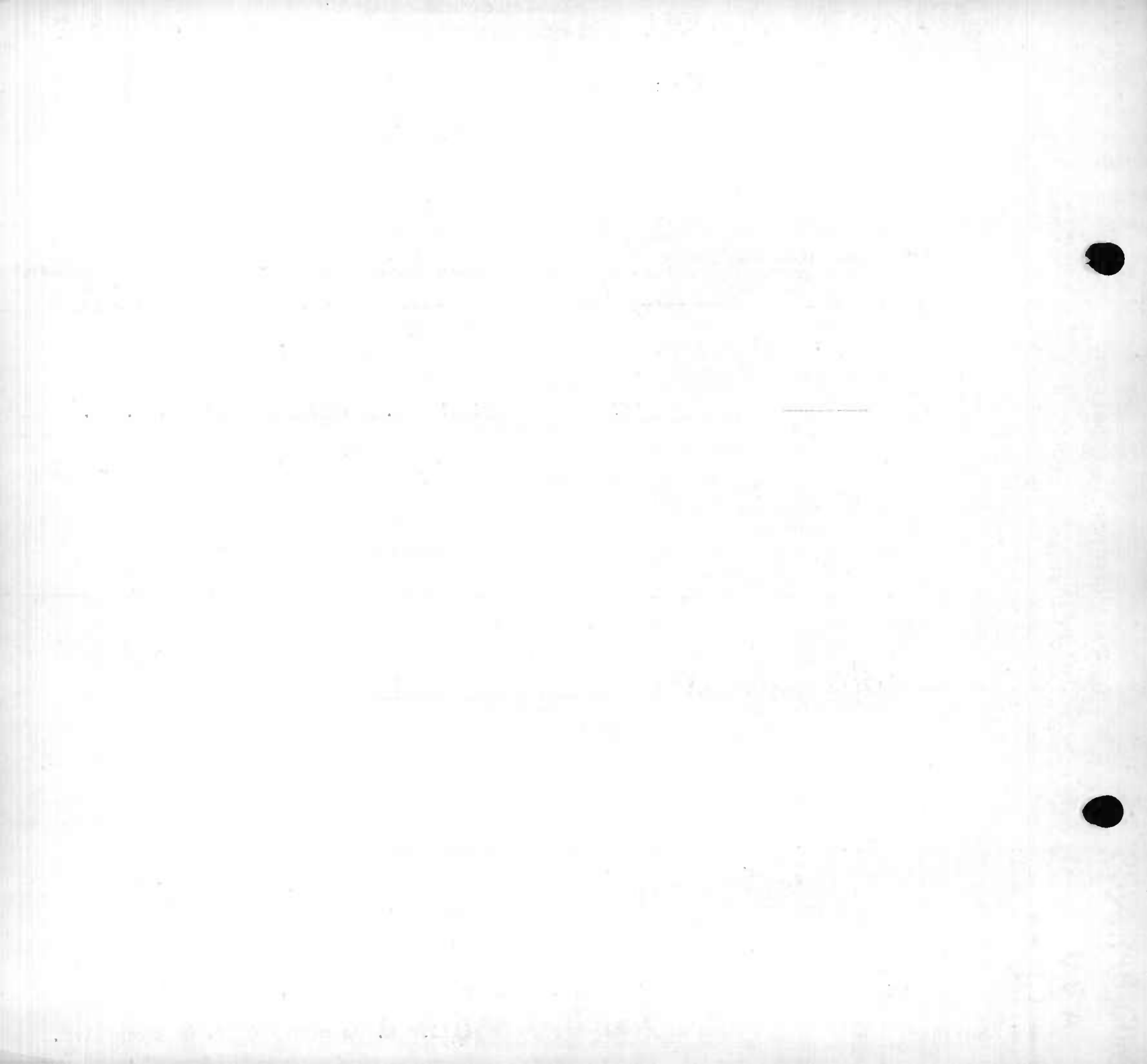
H-655		70 00910		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00910	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Harmon, Raye M</i>				Jan. 11-1970 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
<i>Bon Secours Hospital</i>				Md. 1538			
5. SEX F 6. RACE W				C. CITY OR TOWN 21216		D. INSIDE CITY LIMITS?	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 8/1/1890				E. STREET AND NUMBER			
9. AGE (in years last birthday) 79				3818 Woodhaven Avenue			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Goodmonson, John J.				Hodges, Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				212306458		Admission Sheet.	
18. 5-93.1-153.8				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Acute renal failure			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Tubular necrosis			
II				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Adenocarcinoma of Colon-Diverticuli and ASCVD			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-13-1969 to 1-11-1970 that (I) (we) last saw the deceased alive on 1-11-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Agustin del Campo MD</i>				1/11/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
AGUSTIN del CAMPO MD				Bon Secours Hosp. Balt. Sm			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		1/13/70		Woodlawn Cem		Woodlawn Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 26 1970		Robert E. Fisher, R.D.		Wm S. Pickens & Sons		North at Penna	



# FUNERAL DIRECTOR: IMPORTANT

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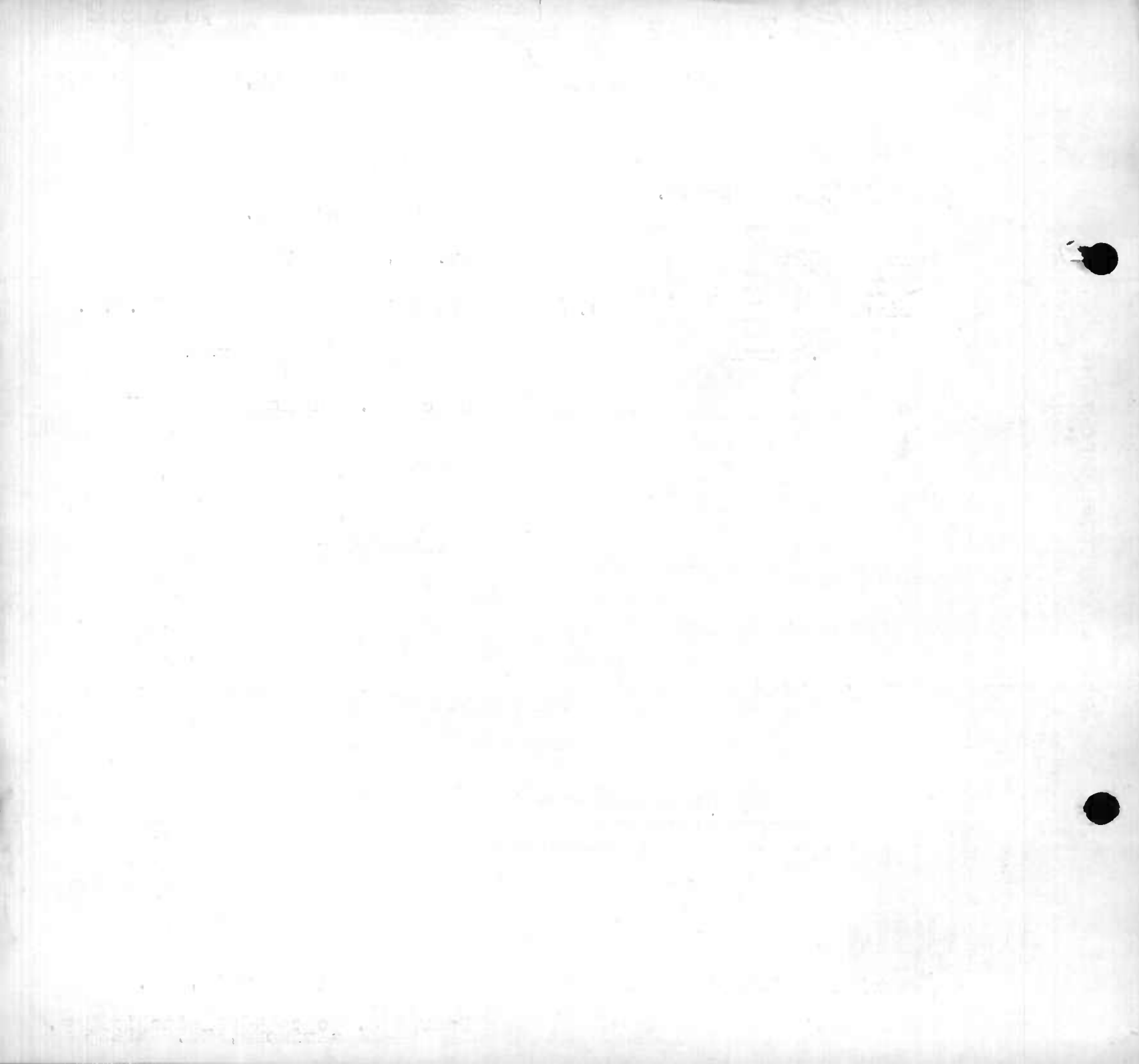
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 009111	
P-626 70 009111		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Peyton Parker</b>		2. DATE AND HOUR OF DEATH <b>1/22/70</b> <b>3:55 P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 UNIVERSITY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>West Va</b> B. COUNTY <b>V-45</b> C. CITY OR TOWN <b>Romney</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt #6</b>			
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/01</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>West Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alfred Parker</b>		14. MOTHER'S MAIDEN NAME <b>Susan Fox</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No?</b>		16. SOCIAL SECURITY NO. <b>236 58 1184</b>		17. INFORMANT <b>William V. Parker</b> ADDRESS <b>Romney, W. Va.</b>	
18. <b>1877 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>C of Bladder</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>3/15/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>men str</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DeMita E. Johnson MD</b>		23B. DATE SIGNED <b>1/22/70</b>		23C. PHYSICIAN'S NAME (Type) <b>DeMita E. Johnson MD</b>	
23D. ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/25/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Indian Mound Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Romney, West Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b>		25C. FUNERAL DIRECTOR <b>William E. Johnson</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

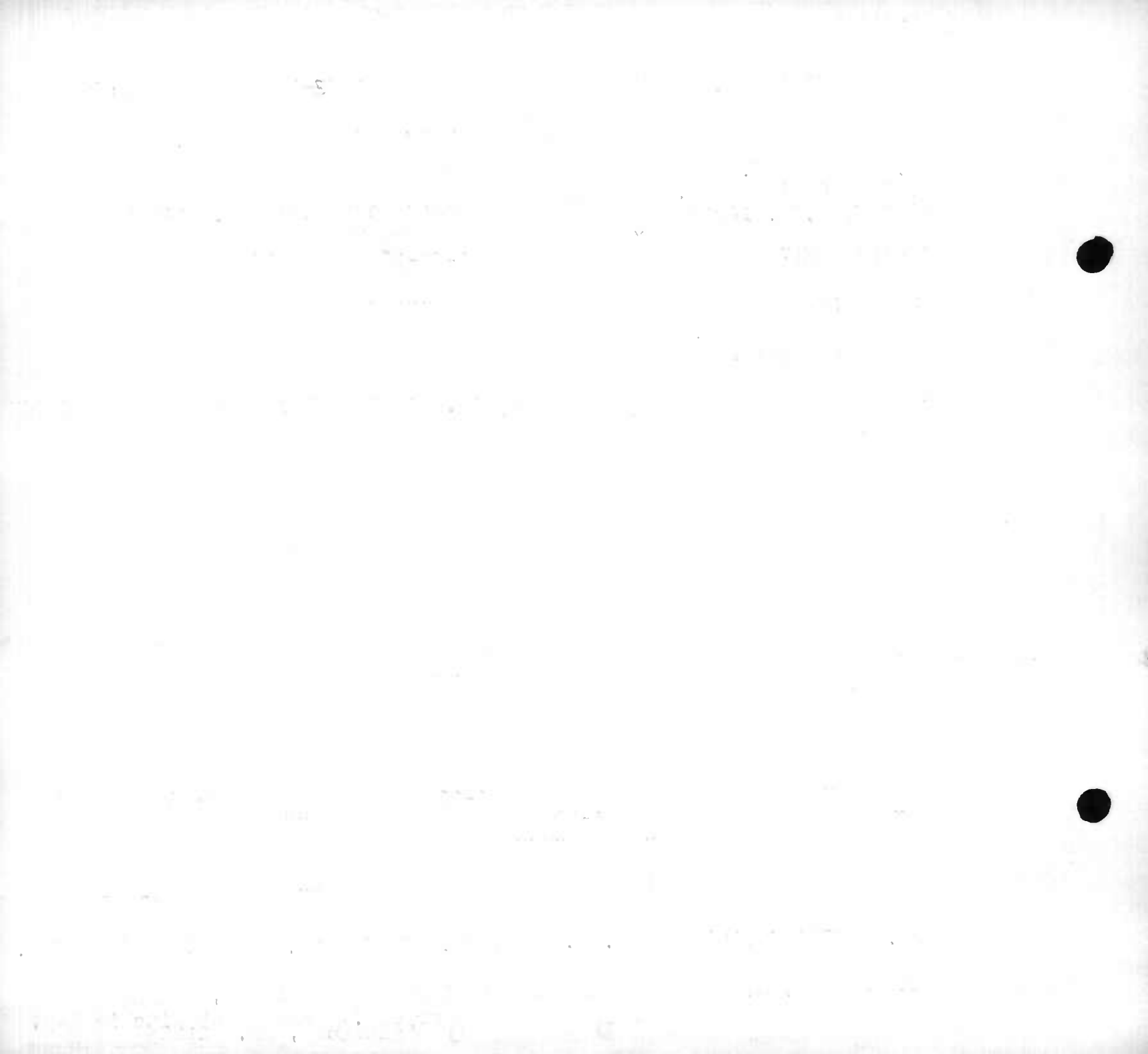
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 00912</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">P-624</span> <span style="font-size: 1.5em;">70 00912</span>					
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Jesse Curtis Pursley</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">January 22, 1970</span> <span style="font-size: 1.2em;">3:30 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">1107 Seaboard Ct.</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2535</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1107 Seaboard Ct.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Nov. 22, 1897</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">72</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Driver</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Cab Co.</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">John P. Pursley</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Marks</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">179-01-125</span>			<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Frances E. Pursley</span>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">CA of the lung</span> (B) <span style="font-size: 1.5em;">Pulmonary emphysema &amp; severe fibrosis</span> (C)		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).</b> <span style="font-size: 1.5em;">Recent fracture of arm, Colony resection</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		(If in Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Nick P. Moutsoor</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1/24/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em;">NICK P. MOUTSOOR M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">95 Aqueduct Rd, Glen Burnie</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1/26/70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Glen Haven</span>	
<b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">Glen Burnie, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 26 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">George J. Gonce</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">4001 Ritchie Hwy. Baltimore, Md. 21225</span>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00913</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MCVICKER, RUTH		1-23-70		6:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
ST. AGNES HOSP. WILKENS & CATON AVE. BALTIMORE, MD. 21228		MARYLAND		BALTO CO. <u>5300</u>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOUSEWIFE				03-02-29	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Thomas Eittson				40	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		539 24 8007		ST. AGNES RECORD ROOM WILKENS & CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE			
		DUE TO, OR AS A CONSEQUENCE OF:			
		(B) UNKNOWN ETIOLOGY			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 1-23-70 to 1-23-70 that (X) (we) last saw the deceased alive on 1-23-70 and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Veena Govila.		1-23-70		DR. VEENA GOVILA	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
ST. AGNES HOSP. WILKENS & CATON AVE.		Burial		1/27/70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Cedar Hill Cemetery		Baltimore, Maryland		JAN 26 1970	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
George J. Gonce		George J. Gonce		4001 Ritchie Hwy. Baltimore, Md. 21225	

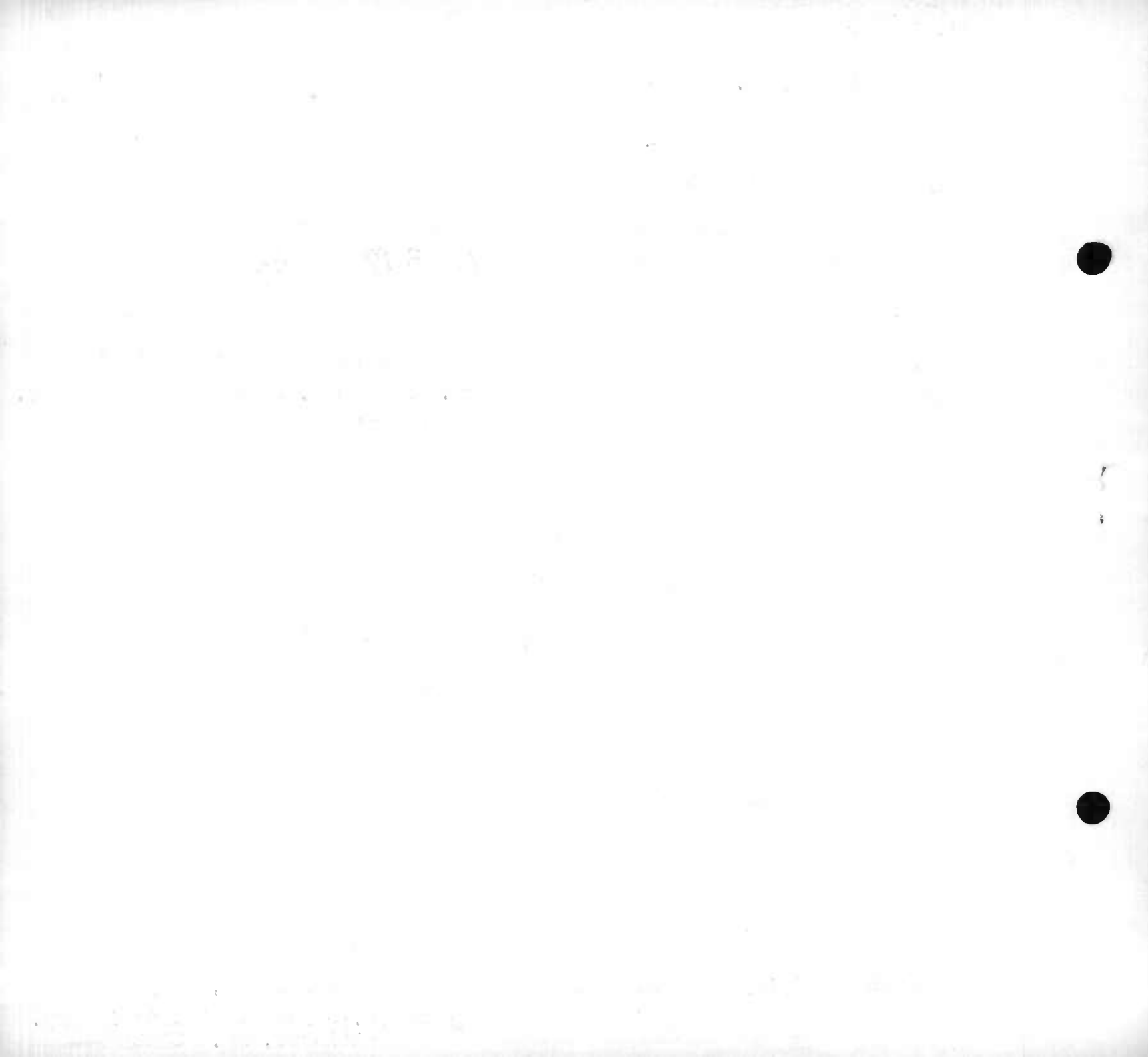




# FUNERAL DIRECTOR: IMPORTANT

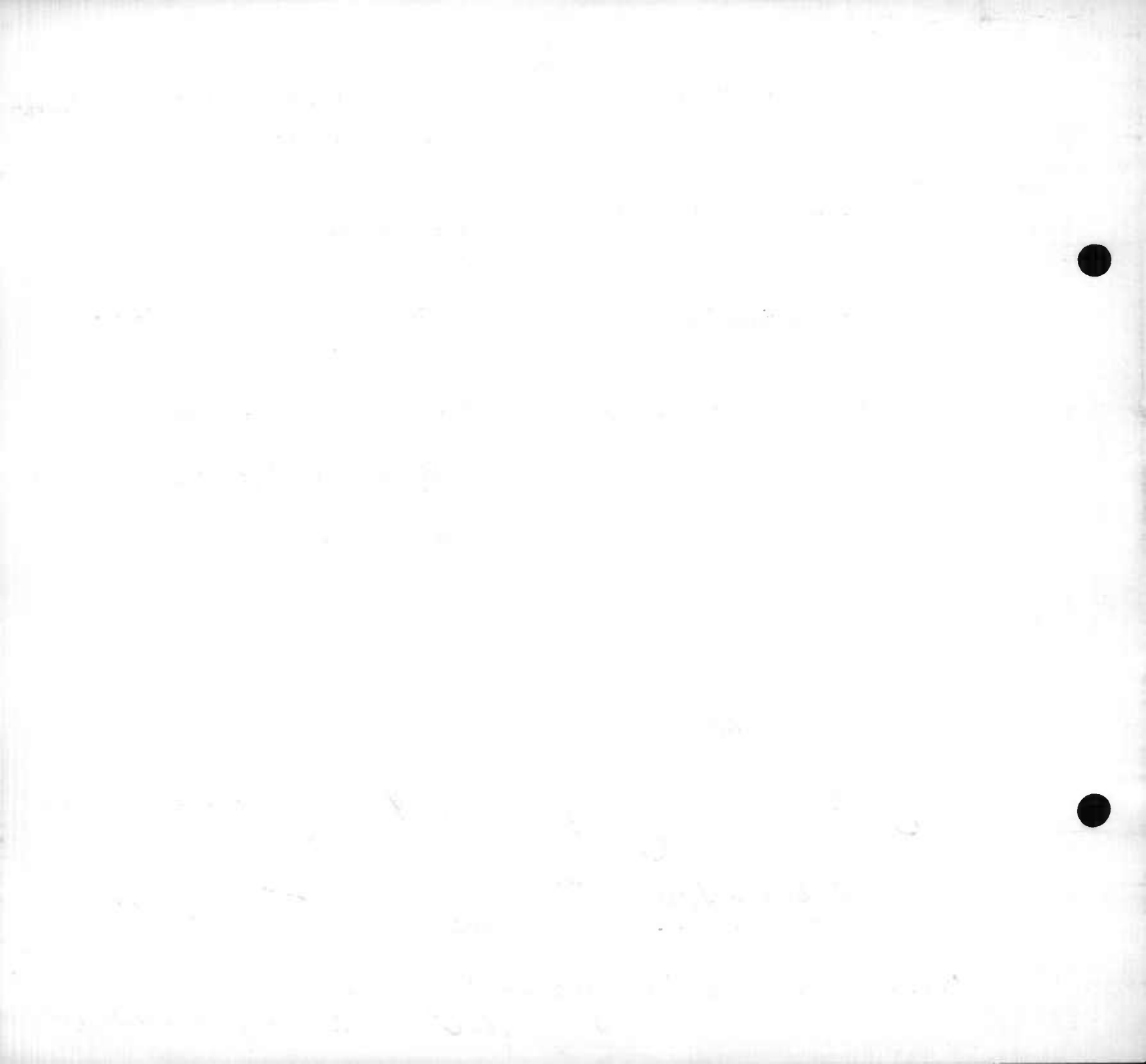
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 00914</u>	
C-200		BIRTH NO. <u>70 00914</u>		1. NAME OF DECEASED (Type or Print) <u>AGNES D. CHASKI</u>		2. DATE AND HOUR OF DEATH <u>1-24-70</u> <u>1<sup>10</sup> A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTO. GEN. HOSP.</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>BALTO</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>602 CHURCH ST.</u>	
5. SEX <u>F</u>	6. RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1900</u>	9. AGE (In years last birthday) <u>69</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
11. BIRTHPLACE (State or foreign country) <u>Poland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Thomas DEBROSTA</u>			14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Frances Zaharcko</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred C. Balint 602 Church St.</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cardiac Arrest</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial Infarction</u> <u>ASCVD</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINS</u> <u>DAYS</u> <u>YEARS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Multiple Cardiac Arrhythmias</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-17-</u> 19 <u>70</u> to <u>1-24</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arnald M. Wood, M.D.</u>				23B. DATE SIGNED <u>1-24-70</u>		23C. PHYSICIAN'S NAME (Type) <u>DONALD M. WOOD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/27/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>George J. Gonce</u>			
25D. ADDRESS <u>4001 Ritchie Hgy. Baltimore, Md. 21225</u>							



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BIRTH NO. <b>S-562</b>		70 00915		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 70 00915	
1. NAME OF DECEASED (Type or Print) <b>AGNES R. SHINNORS</b>				2. DATE AND HOUR OF DEATH <b>January 24, 1970 9:30 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BALTIMORE CITY HOSPITALS</b> <b>1940 Eastern Avenue</b> <b>Baltimore, Maryland 21222</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3116 Short Way 21222</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-94</b>		9. AGE (In years lost birthday) <b>75</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>065-10-3779</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH:Records Baltimore, Maryland 21224</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> 19 <b>70</b> to <b>1/24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edward Lee</b> M.D. DEGREE				23B. DATE SIGNED <b>1/24/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Edward Lee M.D.</b>			
23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue Baltimore, Maryland</b>				23E. FUNERAL DIRECTOR <b>Robert E. Taylor, M.D.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-27-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BROOKLYN, N.Y.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert E. Taylor, M.D.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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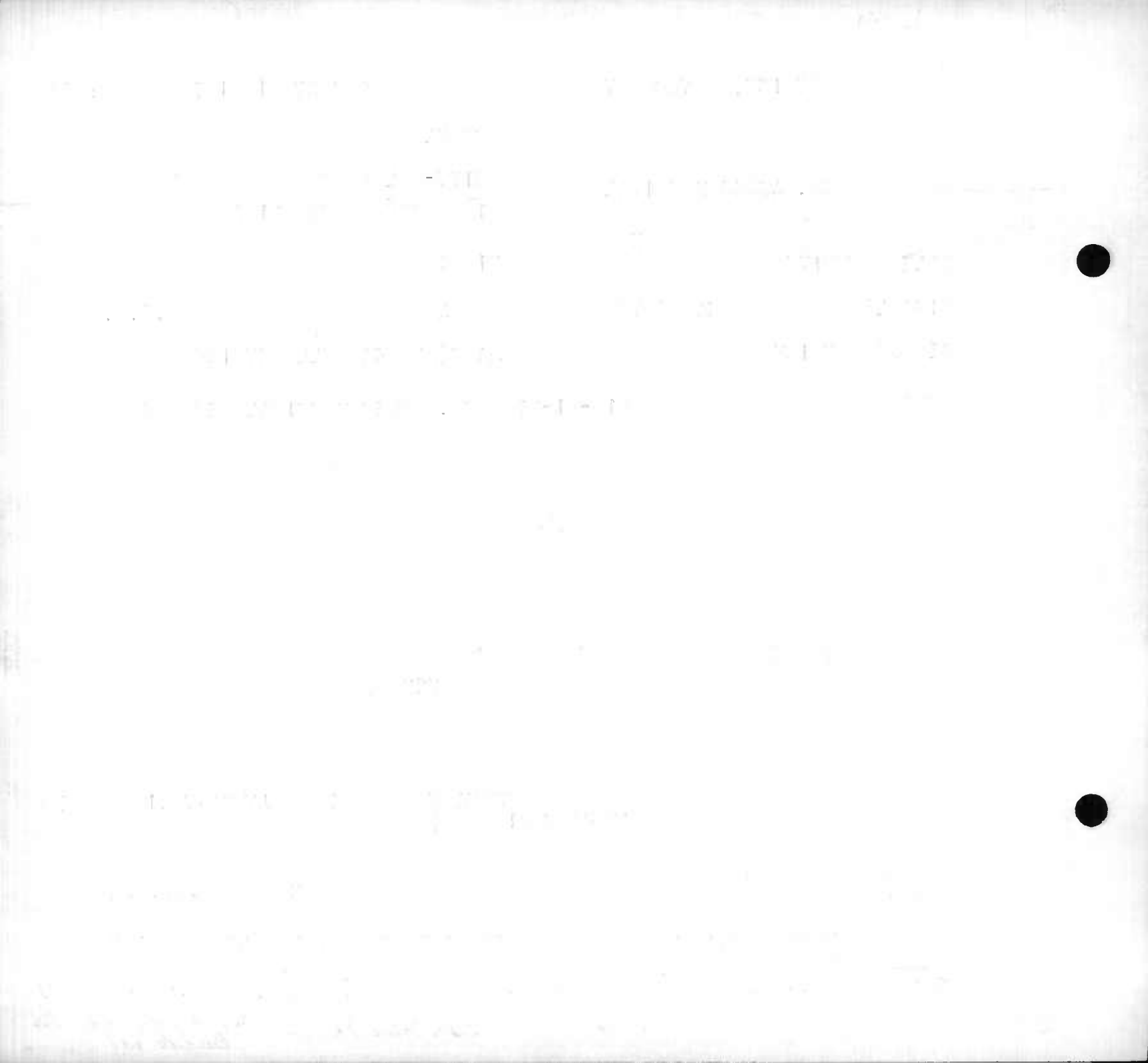
B-626 70 00916		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00916	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ERNEST F. BARKER</b>		2. DATE AND HOUR OF DEATH <b>1/24/1970</b> <b>6—</b> <b>PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1307</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 500 UNIVERSITY PKWY BALTIMORE, MD. 21210</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROFESSOR - UNIVERSITY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNIVERSITY</b>		8. DATE OF BIRTH <b>3-16-1886</b>	
13. FATHER'S NAME <b>CHARLES BARKER</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE FEETHAM</b>		9. AGE (In years lost birthday) <b>83</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>373-38-9154</b>		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
		17. INFORMANT <b>STEPHEN F. BARKER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. <b>590.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Pyelonephritis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Uremia</b> (B) <b>Chronic Pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CHRONIC Brain Syndrome</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 65</b> to <b>Jan 19 70</b> , that (I) (we) last saw the deceased alive on <b>Dec 26 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francis T. Daly MD</b>		23B. DATE SIGNED <b>1/24/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Francis T. Daly MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>1/26/1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CRE.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>W. E. CHASE</b>		25C. FUNERAL DIRECTOR <b>W. E. CHASE</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>		25D. ADDRESS <b>4003 KESWICK RD 21211</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-620		70 00917		70 00917	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
WEYRICH, RAYMOND T			JANUARY 21, 1970 2:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY 2553		
5. SEX MALE			6. RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/12/06		
9. AGE (In years last birthday) 63			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE WEYRICH			14. MOTHER'S MAIDEN NAME MARY (NEE CARROLL) WEYRICH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. 212-01-9748		
17. INFORMANT 8 ST. AGNES HOSPITAL RECORDS			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) XX NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from JANUARY 20 1970 to JANUARY 21 1970 that (I) (we) last saw the deceased alive on JANUARY 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BIZHAN EBRAHMY MD.			23B. DATE SIGNED 1/21/70		
23C. PHYSICIAN'S NAME (Type) BIZHAN EBRAHMY			23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229		
24A. BURIAL CREATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1/24/70		ST. Louis Cem.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Clarksville Howard Md		JAN 26 1970			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Eberly MD		E.O.B. MacNeil		301 Frederick Rd	

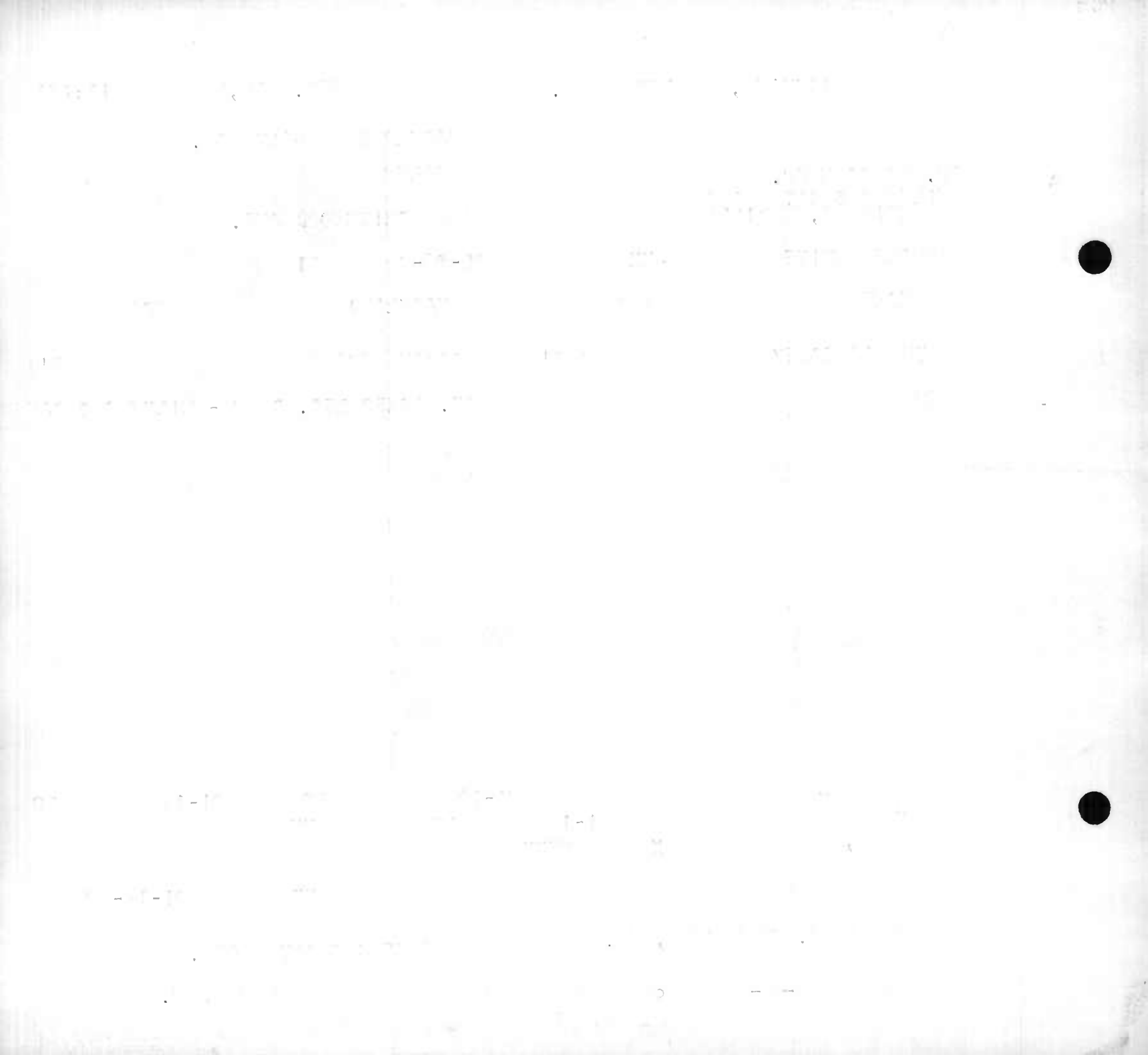




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

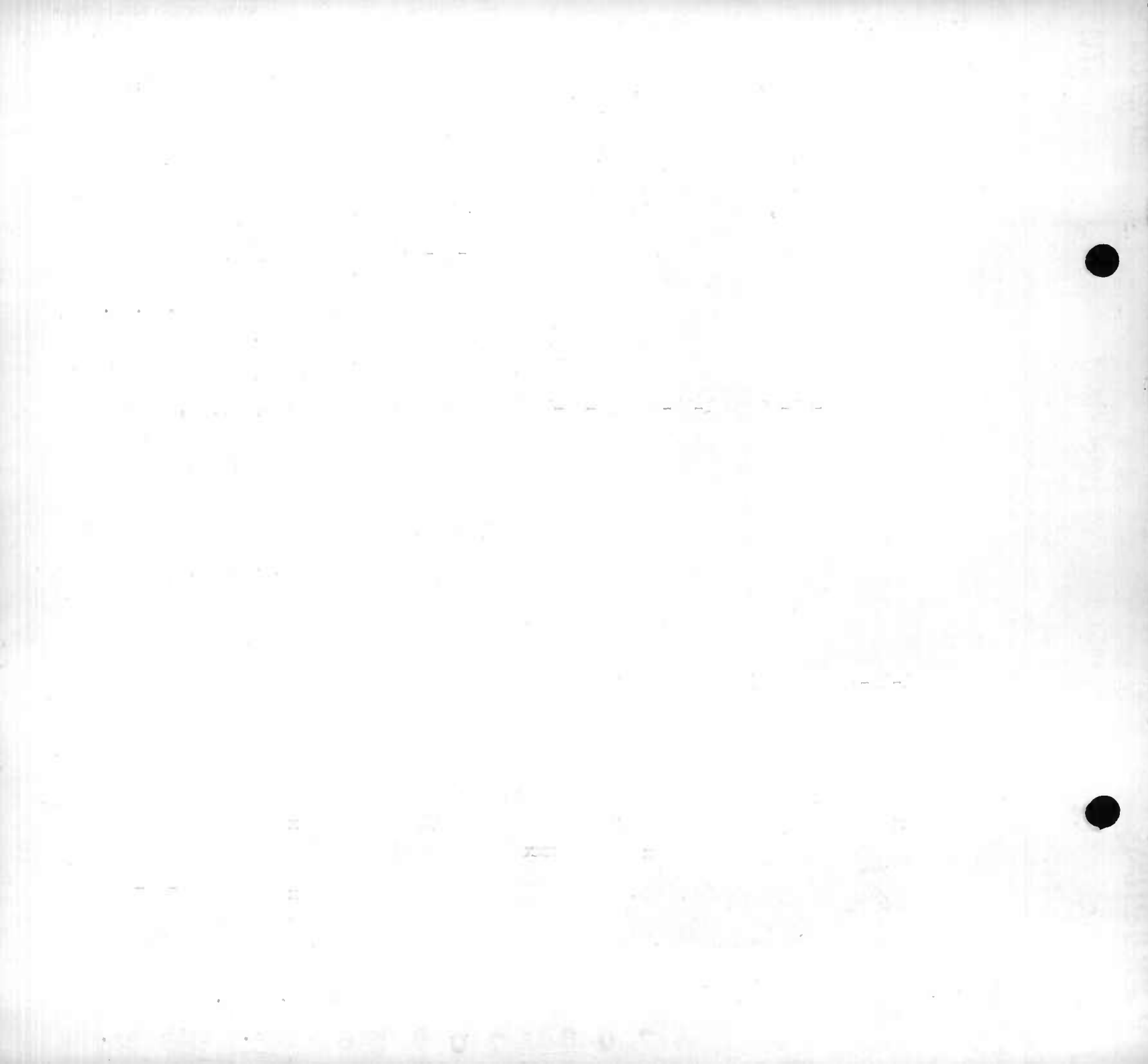
X-523 70 00918		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 00918	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KNICKMAN, BERTHA M.		JAN. 19, 70 11:10A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSP. WILKENS & CATON AVE BALTIMORE, MD 21228		MARYLAND BALTO CO. 5300			
		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 98 SMITHWOOD AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-06-98	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS ESPEY DEC 'D		14. MOTHER'S MAIDEN NAME SARAH MEYERS DEC 'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES REC. ROOM - WILKENS & CATON	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DIABETES MEL.; UNCONTROLLED yrs/5days (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Card. Vasc. Dis. yrs.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 01-14 19 70 to 01-19 19 70 that (X) (we) last saw the deceased alive on 1-19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Laurence R. Gallagher, MD.		23B. DATE SIGNED 01-19-70		23C. PHYSICIAN'S NAME (Type) LAURENCE R. GALLAGHER, MD.	
23D. ADDRESS WILKENS & CATON AVE		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-1970		24C. NAME OF CEMETERY or CREMATORY Good Shepherd Cemetery	
24D. LOCATION Ellicott City, Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR'S ADDRESS Caton Funeral Home 608 Frederick Rd.		24H. NAME OF REGISTRAR U O O		24I. FUNERAL DIRECTOR'S ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

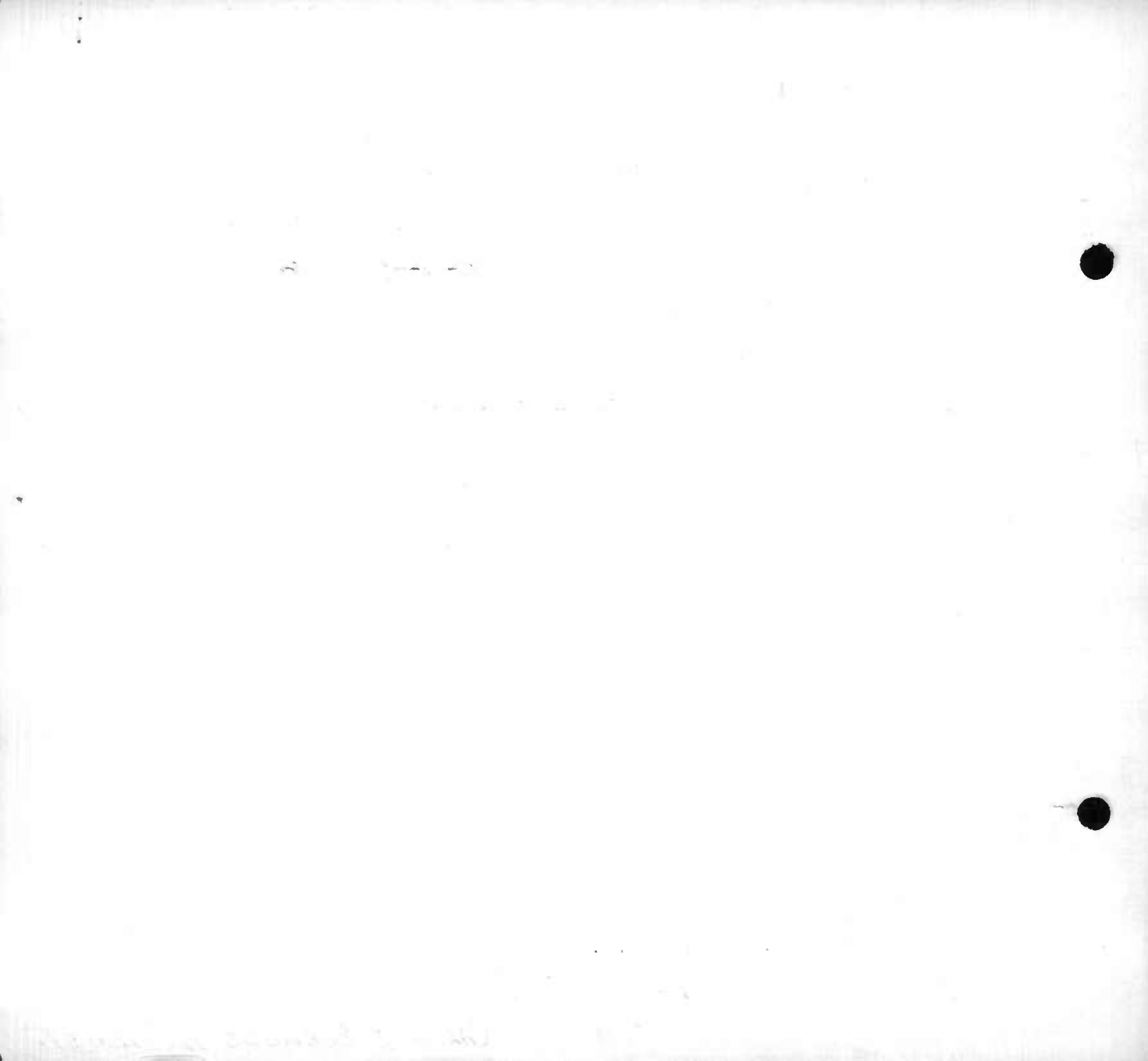
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00919</span>	
70 00919				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: left;">S-600</span>					
1. NAME OF DECEASED (Type or Print) <b>GRAY, James Early</b>			2. DATE AND HOUR OF DEATH <b>22 JANUARY 1970 3:25 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2248 CECIL AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-14</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BUCKINGHAM CO, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ROBERT GRAY</b>		14. MOTHER'S MAIDEN NAME <b>ANNE BROWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 10-23-42 TO 1-14-46</b>		16. SOCIAL SECURITY NO. <b>219-07-3758</b>		17. INFORMANT <b>VA HOSPITAL RECORDS</b> ADDRESS <b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA (BILATERAL)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY THROMBOEMBOLISM</b> <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>7 DAYS</b> <b>MANY YEARS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3 1-14-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RT CAROTID ENDARTERECTOMY</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>15 DECEMBER 1969</b> to <b>22 JANUARY 1970</b> , that <b>70</b> (we) last saw the deceased alive on <b>22 JANUARY 1970</b> and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carl E. Bredenberg MD</b>				23B. DATE SIGNED <b>1-23-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL BREDEBERG, MD</b>		23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto National Cemetery Balto., Md.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Wm C. Maech</b>		25D. ADDRESS <b>928 E. North Ave.</b>			



THE BODY OF GEORGIA BURTON HAS BEEN RELEASED AS NON-MED BURTON, Georgia  
FUNERAL DIRECTOR: IMPORTANT  
BY DR. KORNBLUM OF THE MEDICAL EXAMINER  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

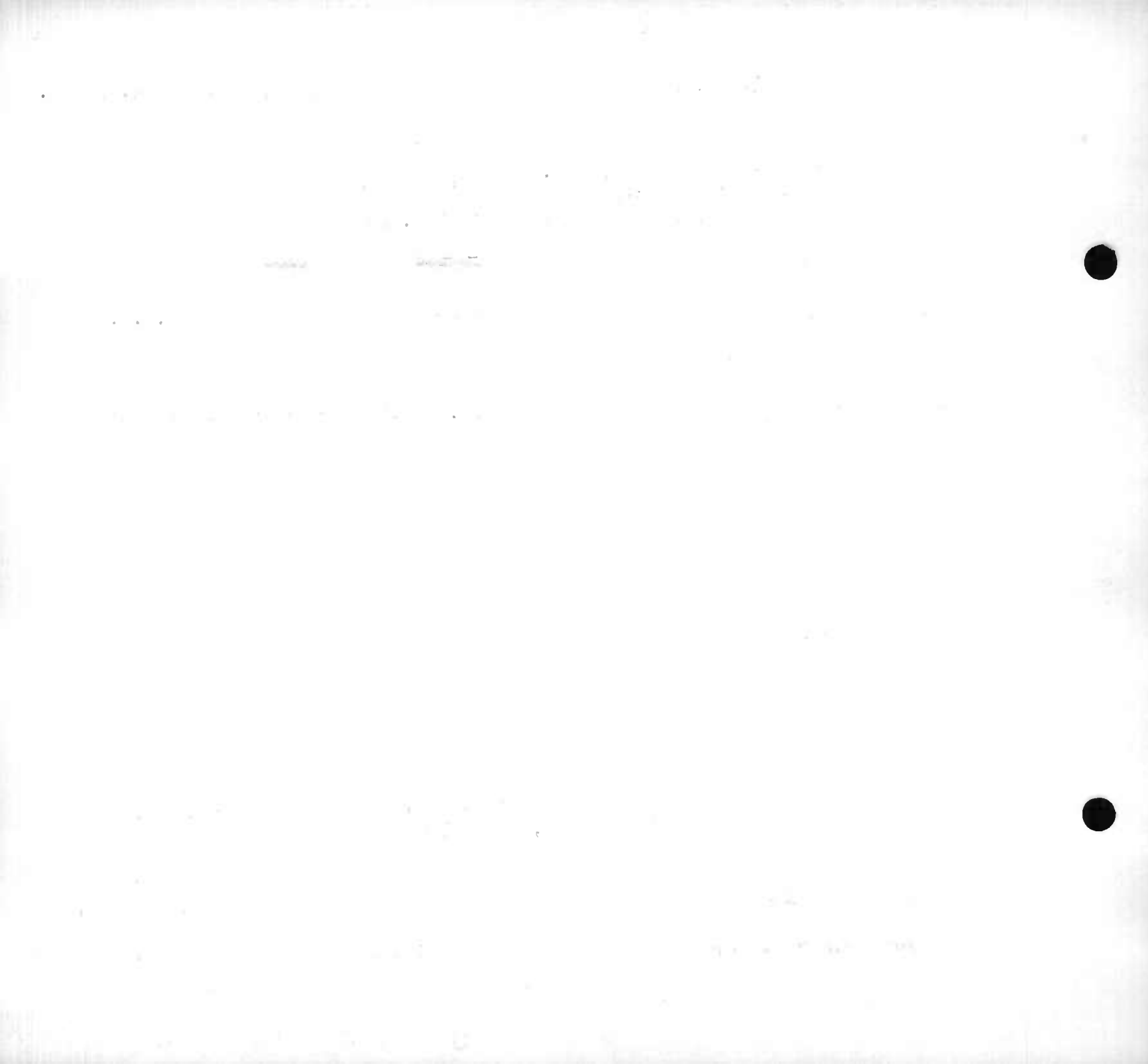
B-635		70 00920		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00920	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GEORGIA GEORGIE BURTON</b>				2. DATE AND HOUR OF DEATH <b>11/24/70 1:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1002</b>			
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b> <b>33</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>918 N. CAROLINE STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-20-01</b>	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>EDGEFIELD S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HOLMES</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-07-4050</b>		17. INFORMANT <b>MARY MANN'S</b> ADDRESS <b>1530 N. CAROLINE ST.</b>			
18. <b>412.2 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>A COPD</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>15 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>HASCVD</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>15 yrs.</b>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/69</b> <b>1969</b> to <b>11/20</b> <b>1970</b> that (I) (we) last saw the deceased alive on <b>1/20</b> <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard W. Light</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD W. LIGHT M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-28-70</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTO. NAT. CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>CAVIN B. SCRUGGS</b> ADDRESS <b>1412 E. FRESTON ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

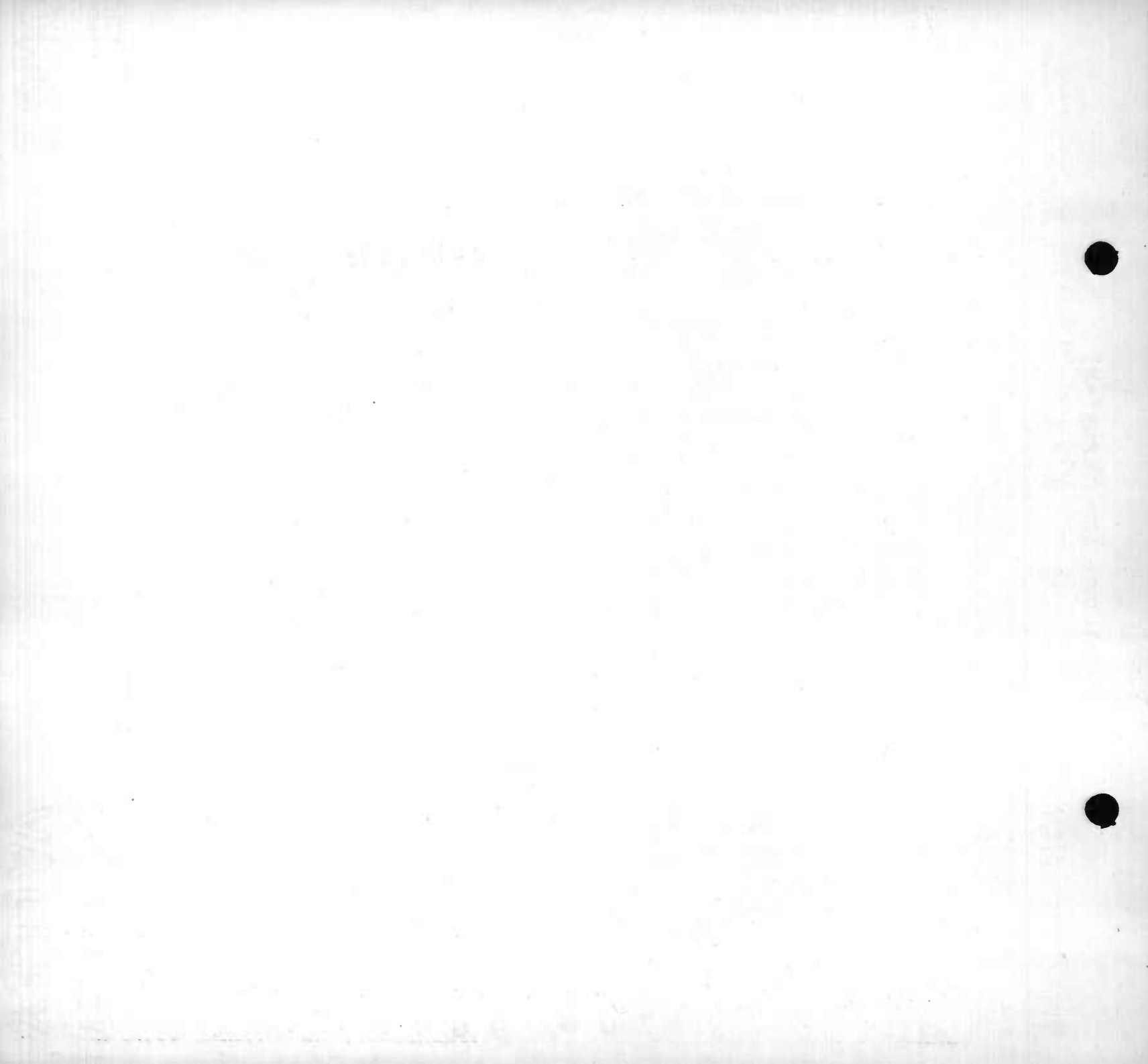
C-654 70 00921				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00921	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>John Cornelius</b>				2. DATE AND HOUR OF DEATH <b>January 24, 1970 1:27 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital, Inc. 1514 Division Street Baltimore Maryland 21217</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>			
5. SEX <b>Male</b>				6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>8-3-02</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>				9. AGE (In years last birthday) <b>67</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Cornilius</b>				14. MOTHER'S MAIDEN NAME <b>Ella Weaver</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W.W.L</b>		17. INFORMANT <b>Mrs. Hattie Cornelius (Wife)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 14, 1970</b> to <b>January 24, 1970</b> that (I) (we) last saw the deceased alive on <b>January 24, 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hamida Z. Alam</b>				23B. DATE SIGNED <b>January 24, 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>HAMIDA Z. ALAM</b>				23D. ADDRESS <b>1514 Division Street Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/28/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City or town or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>W. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>34 N. Schroeder St</b>	





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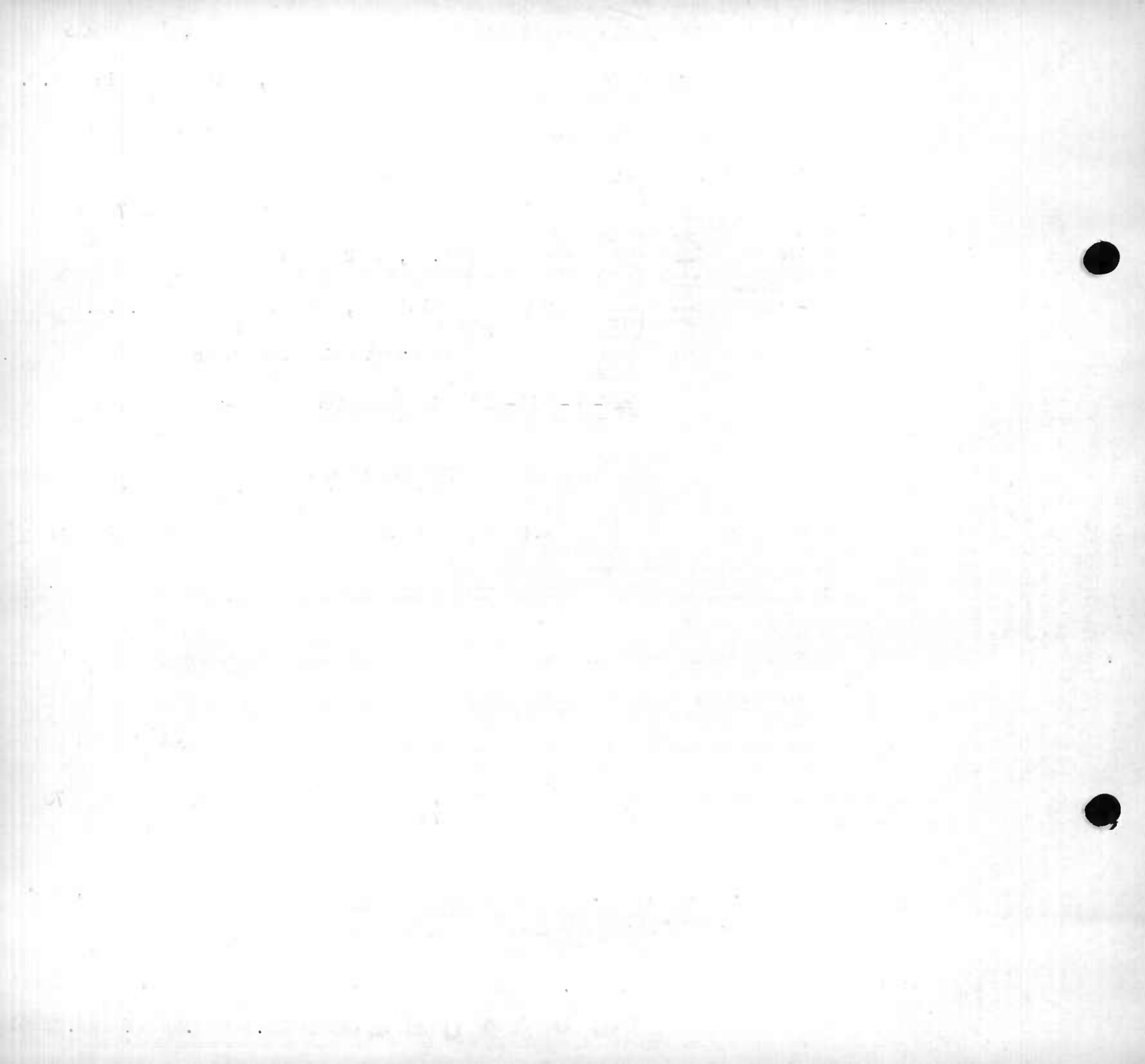
T-425 70 00922		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00922	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TOLSON, ALBERT</b>		2. DATE AND HOUR OF DEATH <b>1-23-1970 12:25 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>730 ASHBURTON ST. BALTIMORE MD 21216</b>		E. STREET AND NUMBER <b>810 W. FREMONT AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1879</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Nanjemoy Md.</b>	
13. FATHER'S NAME <b>Joseph Tolson</b>		14. MOTHER'S MAIDEN NAME <b>MORRY</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bertha Jones 2428 Ellamont St.</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pneumonia.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-20-1970</b> to <b>1-23-1970</b> , that (I) (we) last saw the deceased alive on <b>1-23-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul M.B. B.S.</b>		23B. DATE SIGNED <b>1-23-1970.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>PREM LAL M.B. B.S.</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTIMORE MD 21216.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Nanjemoy Cem. Nanjemoy Md</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones 7-0000</b>	
25C. FUNERAL DIRECTOR <b>W. B. Williams Funeral Home 3199 W. 11th St.</b>		25D. ADDRESS			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00923</u>	
<div style="display: flex; justify-content: space-between;"> <span><u>A-350</u> <u>70 00923</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sister Vincent Adam		January 23, 1970 1:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>94</u> Villa Saint Michael			A. STATE Maryland B. COUNTY City of Baltimore <u>2841</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 4000 Forest Hill Road 21207		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 7, 1882	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Teacher -retired		Sister of Charity		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Charles Adam			Margaret Elizabeth Doyle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-54-0235-J1		Sister Andfea -same address	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Coronary Occulsion		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerosis		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			1 day		
			5 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
None					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June, 1952 to January 1970, that (I) (we) last saw the deceased alive on January 20, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Damian P. Alagia, M.D. DEGREE			January 23, 1970		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Damian P. Alagia			3326 Funderburk		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	1/26/70	Villa St. Michael on grounds, Seton Institute, City		21215	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 27 1970		J. E. Kelly		STEWART & MOYEN CO. 108 W. NORTH AVE. 21201	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00924</u>	
BIRTH NO. <u>A-450</u>		70 00924	
1. NAME OF DECEASED (Type or Print) <u>Luther E. Allen</u>		2. DATE AND HOUR OF DEATH <u>1/24/70</u> <u>12:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>MD</u> B. COUNTY <u>1202</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3509 N. Calvert</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/07</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		9. AGE (In years last birthday) <u>62</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morton P. Allen</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Childs</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>257-20-2568</u>	
		17. INFORMANT ADDRESS <u>Mr. Ronald Allen, Fallston, Md.</u>	
18. <u>4928</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia R.L.L.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Emphysema -</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>es</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/19/70</u> to <u>1/24/70</u> that (I) (we) last saw the deceased alive on <u>1/24/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>1/24/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md.</u>		ADDRESS	



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BALTIMORE CITY HEALTH DEPARTMENT				70 00925	
B-654				70 00925	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>JAMES BRUMMELEN</b>				2. DATE AND HOUR OF DEATH <b>1-25-1970 1:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS</b> <b>31</b> <b>2-11-1970</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>1824 WILSON RT. ROAD</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/12/96</b>	9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEA CAPTAIN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SEA CAPTAIN RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>HOLLAND Holland</b>	
13. FATHER'S NAME <b>DAVID BRUMMELEN</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>130-42-1893A</b>	
17. INFORMANT <b>OCTAVIA BRUMMELEN</b>				ADDRESS	
18. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>S.S.#130 12 8293A</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONGESTIVE HEART FAIL 6 MOS.</b> <b>ASCVD</b> <b>CHRONIC ATRIAL FIBRILLATION 8 YEARS.</b> <b>IDIOPATHIC MYOCARDITIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CARDIAC CIRRHOSIS</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/21/70</b> 19 <b>70</b> to <b>1/24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jaime F. Casellas M.D.</b>				23B. DATE SIGNED <b>1/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAIME F. CASELLAS M.D.</b>				23D. ADDRESS <b>6012 E. PRATT ST. BALTO MD. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/70.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>John E. [illegible]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

Letter from B.C.H. & V.S. 153

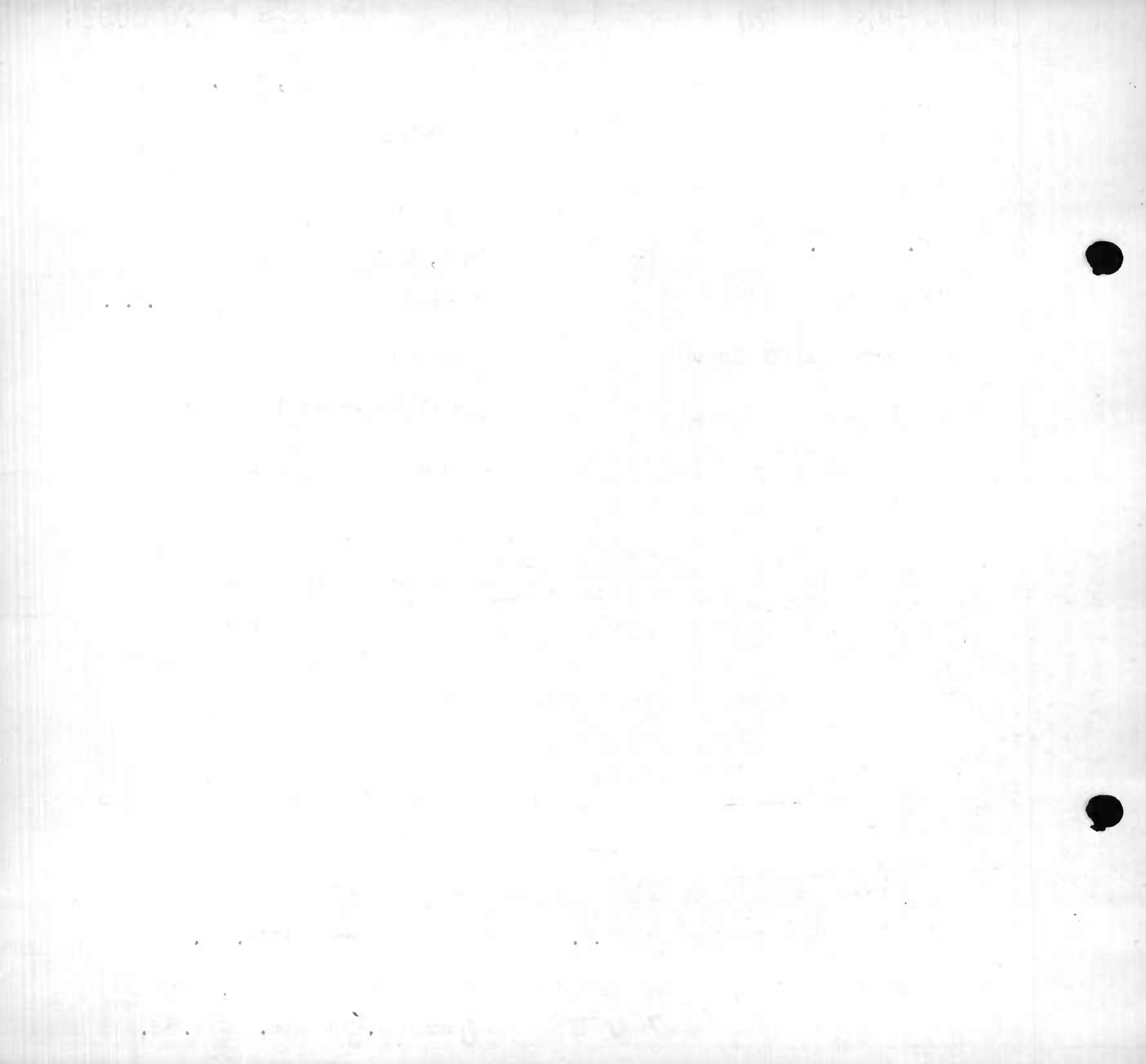
2-11-70 M.H.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00926</span>	
<div style="display: flex; justify-content: space-between;"> <span><b>L-520</b></span> <span><b>70 00926</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Amelia Lens</b>		2. DATE AND HOUR OF DEATH <b>January 25, 1970. 10:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in Pines Belair Road</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>721 Hillen Rd</b>		
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 9, 1873</b>	9. AGE (In years lost birthday) <b>96</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Engnoth</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Eleanora ?</b>		16. SOCIAL SECURITY NO.
17. INFORMANT <b>Mrs Alvina McDonald</b>			ADDRESS <b>Same</b>		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Recurrent Pneumonia</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cachexia &amp; Dehydration</b></p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Possible Sublethal Hemorrhage</b></p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1/24/1970</b> to <b>1/25/1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/24/1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Albert Bradley</b>				23B. DATE SIGNED <b>1/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Albert Bradley</b>				23D. ADDRESS <b>4900 Belair Road Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/70</b>		24C. NAME of CEMETERY or CREMATORY <b>First United Evangelical Church</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Balto. Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

Certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00927	
F-360 70 00927		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JESSIE JANE PETROW			2. DATE AND HOUR OF DEATH Jan. 24, 1970 11:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD'S CONVALESCENTIUM			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 902		
5. SEX female		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Oct. 6, 1886.	
11. BIRTHPLACE (State or foreign country) Scotland		9. AGE (In years lost birthday) 83		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Campbell			14. MOTHER'S MAIDEN NAME Jane Stewart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William McLaughlin ADDRESS (Same)	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident (B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C.V. disease (C) REMOTE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic pulmonary edema Fract. pelvis Nov 16, 1969		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 8 1969 to Jan. 24 1970, that (I) (we) last saw the deceased alive on Jan 24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23A. SIGNATURE Dr. Harold V. Harbold M.D.				23B. DATE SIGNED Jan 26, 1970	
23C. PHYSICIAN'S NAME (Type) Dr. Harold V. Harbold				23D. ADDRESS 4706 Harford Road, Balto, Maryland-14	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/70		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Cemetery Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR R. E. Zeller, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Balto, Maryland-14	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 00928</b>	
<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Martin Frank P. Sr.</b>		2. DATE AND HOUR OF DEATH <b>Jan. 26, 1970 8 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>North Charles General Hosp. Baltimore, Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co.</b>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/15/98</b> 9. AGE (In years last birthday) <b>71</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration engineer</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>George Martin</b>		14. MOTHER'S MAIDEN NAME <b>Ann Elizabeth Albright</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>206-05-8151</b>	
17. INFORMANT <b>Mrs. Julia E. Martin</b>		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Ca lung e metastasis</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>1/22/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>Jan. 16</b> 19 <b>70</b> to <b>Jan. 26</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Jan. 26</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>V. Chitraplee</b>		23B. DATE SIGNED <b>Jan. 26, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. Chitraplee</b>		23D. ADDRESS <b>North Charles General Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Leonard J. Rock Inc.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Rock Inc.</b>		ADDRESS <b>5305 Harford Rd. 21214</b>	

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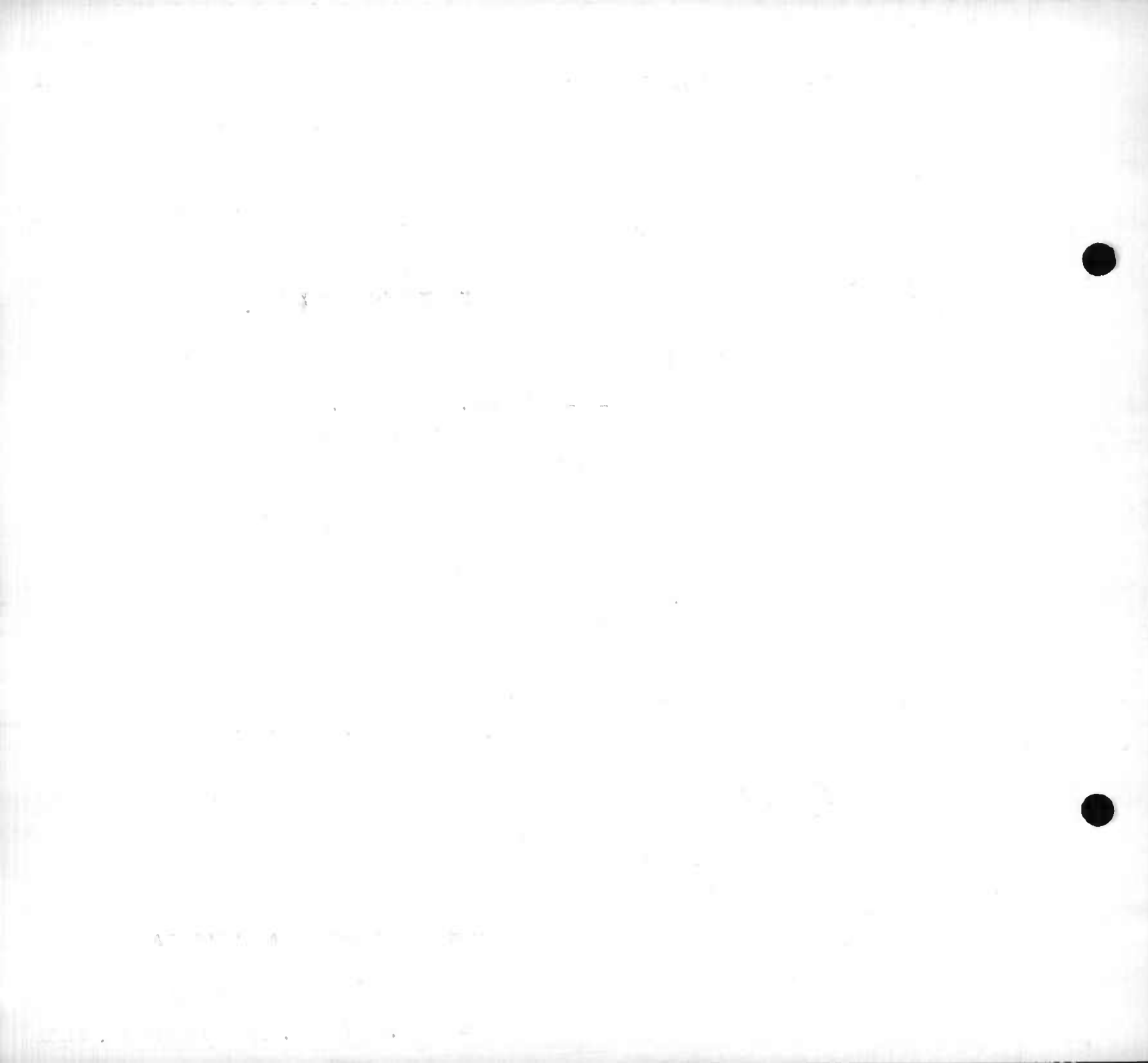
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**FUNERAL DIRECTOR: IMPORTANT**

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F-632		70 00929		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00929	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>FRITZ, CHARLES V</b>		2. DATE AND HOUR OF DEATH <b>1-26-70 12:30 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSPITAL 44</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3148 ELMORA AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>07-19-06</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JOBBE OWNER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRITZ CHARLES</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>212-07-3375</b>		17. INFORMANT <b>Mrs. Margaret E. Fritz</b>	
				ADDRESS <b>Same</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>DECOMP. MITRAL VALVULAR REGURGITATION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>RHEUMATIC HEART DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  <b>LIVER FAILURE - CHRON. CIRRHOSIS</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>this hospital</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>01-10-70</b> to <b>01-26-70</b> that (I) (we) last saw the deceased alive on <b>01-25-70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Paul Mikul</b>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>J. Paul Mikul</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly, M.D.</b>		25C. FUNERAL DIRECTOR <b>Edward J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Rd. 21214</b>	

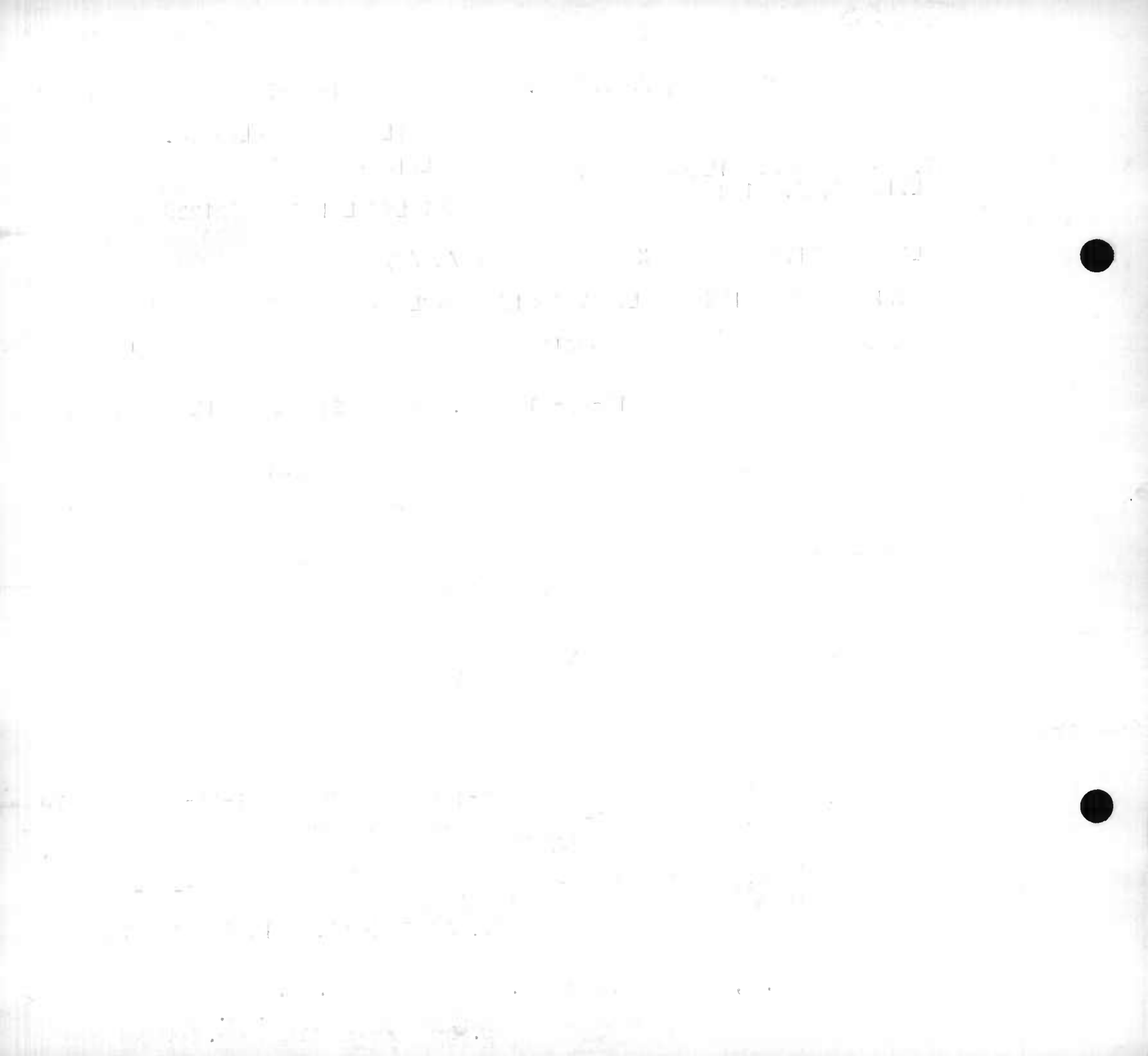




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00930	
BIRTH NO. 5-620 70 00930		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHEARS, JOSEPH M.			2. DATE AND HOUR OF DEATH 1-22-70 9.45 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSP. WILKENS & CATON BALTIMORE, MD. 21228			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 03 /28/87		9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BUS DRIVER			10B. KIND OF BUSINESS OR INDUSTRY BALTO TRANSIT		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME MARK SHEARS			14. MOTHER'S MAIDEN NAME DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-05-9198		
17. INFORMANT ST. AGNES RECORDS			ADDRESS WILKENS & CATON		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE BONCHO PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: RT LOBE (B) A.S.C.V.P. DUE TO, OR AS A CONSEQUENCE OF: (C) ST. EMPHYSEMA					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1-17-1970 to 1-22-1970 that (X) (we) last saw the deceased alive on 1-22-1970 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. AFZAL MD				23B. DATE SIGNED 1-22-70	
23C. PHYSICIAN'S NAME (Type) M. AFZAL MD				23D. ADDRESS ST. AGNES HOSP. WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 26, 1970		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR G. Truman Schwab		25C. FUNERAL DIRECTOR Balto. Md. 21229 ADDRESS 5151 Balto. National Pike	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. <span style="font-size: 1.5em;">70 00931</span>									
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print)		<b>ELLA SEDLACK</b>				<b>2. DATE AND HOUR OF DEATH</b> Jan. 24, 1970      9:50 a. M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">00</span> 525 N. Highland Avenue						<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE      B. COUNTY Md.,      21205			
<b>5. SEX</b> female						<b>6. RACE</b> white		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Seamstress						<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Nurses Uniform Co		<b>8. DATE OF BIRTH</b> 4/4/1892	
<b>13. FATHER'S NAME</b> Anton Sedlack						<b>14. MOTHER'S MAIDEN NAME</b> Mary Linhardt			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> 216-07-5855		<b>17. INFORMANT</b> Matilda Sedlack, sister, above	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized Metastasis</i> (B) <i>Ca - Ovaries</i> (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 1 yr. 3 yrs. 5 yrs.	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						<i>Hypertension</i>			
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)			
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Jan 1960</i> <b>to</b> <i>Jan 24 1970</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 24 1970</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Dr. Louis F. Klimes</i>						<b>23B. DATE SIGNED</b> <i>Jan 26, 1970</i>		<b>23C. PHYSICIAN'S NAME</b> (Type) Dr. Louis F. Klimes	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial						<b>24B. DATE</b> 1/26/70		<b>24C. NAME OF CEMETERY or CREMATORY</b> Bohemian National Cem.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 27 1970						<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Halley</i>		<b>25C. FUNERAL DIRECTOR</b> Schindler General Home, Inc. 73331 Brehms Lane	

1871

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T-640

70 00932

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00932

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mollie</b> <b>AMANDA THURLOW</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>24</b> Year <b>1970</b>		Hour <b>2:30</b> P.		M.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2734</b>		6. SEX <b>Female</b> 7. RACE <b>White</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>Aug. 15, 1886</b>		10. AGE (In years lost birthday) <b>83</b>		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>4000 Century Road</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Garrett Hughes</b>				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		15. MOTHER'S MAIDEN NAME <b>?</b>				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>216-03-5035</b>		18. INFORMANT <b>Carroll Thurlow, son, above</b>		ADDRESS		

MEDICAL CERTIFICATION	19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
	20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
	22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
	23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
	ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/25/70</b>
	24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>
	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		
	25B. NAME OF REGISTRAR <b>Schimunek Funeral Home, Inc.</b>		25C. FUNERAL DIRECTOR <b>9332 Brehms Lane</b>		

1. The purpose of this document is to provide information regarding the status of the project.

2. The project is currently in the planning stage and is expected to be completed by the end of the year.

3. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

4. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

5. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

6. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

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8. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

9. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

10. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

11. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

12. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

13. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

14. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

15. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

16. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

17. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

18. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

19. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

20. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

21. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

22. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

23. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

24. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

25. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

26. The project is being managed by the Office of the Secretary of Defense and is being funded by the Department of Defense.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00933

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Martin (also known as)  
JOHN BLUM-John Thomas Blum2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ SEPARATED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

8/25/1906

10. AGE (In years  
lost birthday)

63

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1822 Eastern Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Martin Blum

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Veystrik

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW2- army

213-01-0478

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

21231

Agnes Holy, sister, 253 Regester St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carcinoma of larynx  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 22, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/24/70

24C. NAME of CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1970

25B. NAME OF REGISTRAR

Robert E. Falber, M.D.

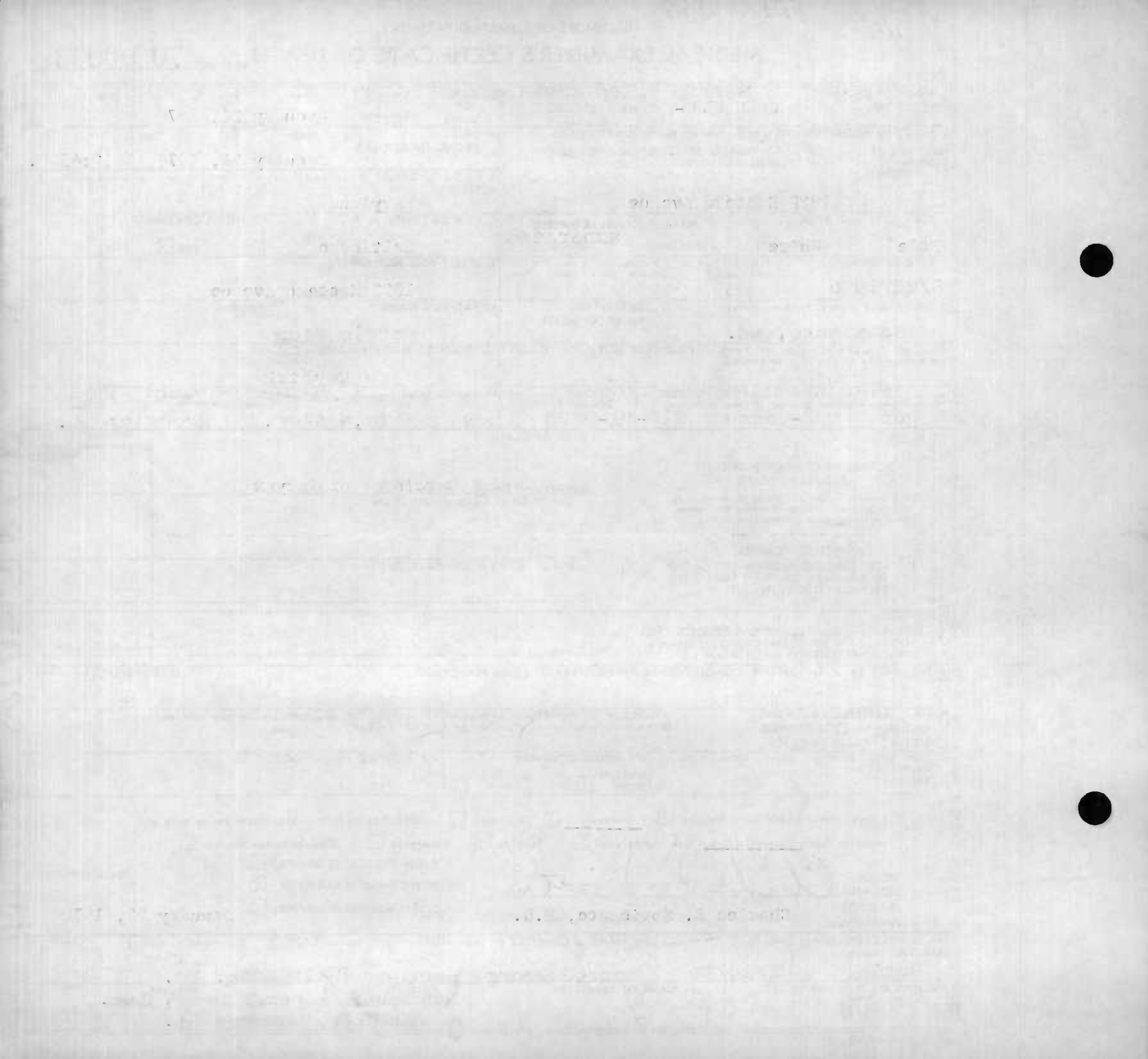
25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601 E. Madison St.







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 00934	
BIRTH NO. 70 00934		CERTIFICATE OF DEATH		REG. NO. 70 00934	
1. NAME OF DECEASED (Type or Print) CHARLES E. NEAL Sr.		2. DATE AND HOUR OF DEATH Jan. 21, 1970 12:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY DISTRICT 601			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. OATE OF BIRTH 4/10/06		9. AGE (in years last birthday) 63		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Back River R.R.		11. BIRTHPLACE (State or foreign country) Maryland Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Neal		14. MOTHER'S MAIDEN NAME Carrie Hanthorn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None.		16. SOCIAL SECURITY NO. 705-10-9439		17. INFORMANT Sarah Neal (wife) ADDRESS 148 N. Decker Ave. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/10.9 + D50.9 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive acute myocardial infarction + possible pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Anterior chest Heart disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus + Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 15 1970 to Jan 21 1970 that (I) (we) last saw the deceased alive on Jan 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando A. Mendez		23B. DATE SIGNED 1/21/70		23C. PHYSICIAN'S NAME (Type) ROLANDO A. MENDOZA, MD	
23D. ADDRESS 100 N. Broadway St (21231)		23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1/26/70		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus Cem. Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR Robert E. Fisher, MD		24F. FUNERAL DIRECTOR Scrimmick Funeral Home, Inc. 3333 Brehms Lane	
24G. DATE REC'D BY HEALTH DEPT. JAN 27 1970		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 70 00935		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00935	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Wilbur (Wilbur L Williams)		January 24, 1970 2:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		Maryland 1601	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1004 Mosher Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-14	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part-Time Druid Hill		10B. KIND OF BUSINESS OR INDUSTRY Reality Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 213-18-6676		17. INFORMANT Miss ROSE CAMPBELL	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) 5990 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram negative Septicemia (B) DUE TO, OR AS A CONSEQUENCE OF: urinary tract infection (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Heart failure, Cirrhosis Liver					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 5, 1970 to January 24, 1970 that (I) (we) last saw the deceased alive on January 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Shafi		23B. DATE SIGNED 1.24-70			
23C. PHYSICIAN'S NAME (Type) M. JAVAD SHAFI		23D. ADDRESS Provident Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/70		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR Halstead 1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-260 70 00936		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00936	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Tucker, Airy Etha</u>		2. DATE AND HOUR OF DEATH <u>Jan. 25, 1970</u> <u>1 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2002</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Maryland Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2821 W Mulberry St</u>	
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>39</u>	9. AGE (In years last birthday) <u>39</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Nathanial Moses</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gardner</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart,</u>	
18. <u>444.21</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>INTESTINAL INFARCTION</u> <u>DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>MESENTERIC THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>DAYS</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2/2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16</u> 19 <u>70</u> to <u>Jan 25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Jan. 25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shao-Huang Chin M.D.</u>		23B. DATE SIGNED <u>1-25-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Shao-Huang Chin M.D.</u>	
23D. ADDRESS		23E. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		23F. ADDRESS <u>1206 W North Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/29/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore Md</u>		24E. NAME OF REGISTRAR <u>John E. ...</u>		24F. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>	



W-623 70 00937

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00937

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MAGGIE WRIGHT

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

January 24, 1970

12:30 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1701

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1/5/00

10. AGE (In years  
last birthday)

70

# Under 1 Yr. # Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

649 Greenwillow Street

11. BIRTHPLACE (State or foreign country)

Farmville Va

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Thad Jones

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Old Age

14B. KIND OF BUSINESS OR INDUSTRY

70

15. MOTHER'S MAIDEN NAME

Lydia

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

MRs Florence Tyler, 910 Penn Ave

19.

412.4 I

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/30/70

24C. NAME of CEMETERY or CREMATORY

MT Auburn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Adolphus Walstead 1206 W north Ave

ACADEMY BOND

APR 10 1911

WILLIAM BOND

WILLIAM BOND



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00938</u>	
1. NAME OF DECEASED (Type or Print) <u>ROY THOMAS REED</u>		2. DATE AND HOUR OF DEATH <u>1/23/70</u> <u>5:20 a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1604</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY OF MARYLAND HOSPITAL</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1813 EDMONDSON AVE. 21223</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/13</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HARVEST WALKER STEEL CO. BROOKLYN</u>		11. BIRTH PLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>GORDON REED</u>			
14. MOTHER'S MAIDEN NAME <u>"BIRDIE"</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MARY MUSE</u> ADDRESS <u>1813 EDMONDSON AVE.</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>PULMONARY EMBOLUS</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(ATRIAL FIBRILLATION) ASCVD</u> <u>(C) —</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) <u>(this hospital)</u> attended the deceased from <u>1/21</u> 19 <u>70</u> to <u>1/23</u> 19 <u>70</u> that (i) <u>(we)</u> last saw the deceased alive on <u>1/23</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (i) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Andrew M. Doyle</u>		23B. DATE SIGNED <u>1/23/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ANDREW M. DOYLE</u>	
23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL</u>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Danville</u>	
24D. LOCATION (City, town, or county) (State) <u>Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Odolphus Walstead</u> ADDRESS <u>1206 W north Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00939	
BIRTH NO. 70 00939					
1. NAME OF DECEASED (Type or Print) <i>Mullen Charles E.</i>			2. DATE AND HOUR OF DEATH <i>Jan. 24, 70 18:45 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Church Home &amp; Hospital 35</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1509 Race St. 21230</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>9-5-06</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Chemical Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles E. Mullen</i>			14. MOTHER'S MAIDEN NAME <i>Lillian Dorsey</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>216-05-3819</i>		17. INFORMANT <i>John Mullen</i> ADDRESS <i>1509 Race St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Malignancy of lung</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 24</i> 19 <i>70</i> to <i>Jan. 25</i> 19 <i>70</i> and that (I) (we) last saw the deceased alive on <i>Jan. 25</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>T.H. Lin</i>			23B. DATE SIGNED <i>Jan. 25, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Tsung Hsi Lin</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>1 29 70</i>		
24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>			24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1970</i>		25B. NAME OF REGISTRAR <i>Charles E. Mullen</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i> ADDRESS <i>130 E. Fort Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 17-240 70 00940				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 00940	
1. NAME OF DECEASED (Type or Print) <b>CAROLINE MOXLEY</b>				2. DATE AND HOUR OF DEATH <b>Jan-23, 1970</b> <b>23 Jan 70 10:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HARFORD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>STREET</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER (REF. #2, Box #218) <b>TRAPPE ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-19</b>	9. AGE (in years last birthday) <b>50</b>	11. Under 1 Yr. Months Days	12. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES MICHAEL</b>				14. MOTHER'S MAIDEN NAME <b>RACHAEL Smith</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>234-24-4130</b>		17. INFORMANT (husband) <b>457-4963</b> <b>Mr. Milton C. Moxley</b>		ADDRESS <b>R.F.D. #2, Box #218 Street, Maryland 21154</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Brain stem decompression</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>6 hr.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>Blue bloater multifar</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>6 wk</b>			
(C).....							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>23 Jan 70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain tumor</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>23 Jan 1970</b> to <b>23 Jan 1970</b> that (1) (we) last saw the deceased alive on <b>23 Jan 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Laurence R. Jelena M.D.</b>				23B. DATE SIGNED <b>23 Jan 70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Laurence R. Jelena</b>				23D. ADDRESS <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 27, 1970</b>		24C. NAME of CEMETERY or CREMATORY <b>BEL AIR Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>BEL AIR, Harford Co, Maryland 21014</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>0000</b>		25C. FUNERAL DIRECTOR <b>Joseph William Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 009411	
BIRTH NO. 70 009411				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Ellis, Eric James</i>			2. DATE AND HOUR OF DEATH <i>1-21-70</i> <sup>40</sup> <sub>P</sub> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37 Mercy Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>905</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3116 Loch Raven Road</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-30-69</i>	9. AGE (in years, lost birthday) <i>8 wks 5 days</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Balt. md</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>John P. Ellis</i>			14. MOTHER'S MAIDEN NAME <i>Marlene Taylor</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>			16. SOCIAL SECURITY NO. <i>NONE</i>		
17. INFORMANT <i>MR. JOHN ELLIS</i>			ADDRESS <i>3116 LOCH RAVEN RD.</i>		
18. <i>746.71</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congenital heart disease since birth</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i> (C) <i>Down's Syndrome</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 wks</i> <i>1: new birth</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>1-8-70</i> to <i>1-21-70</i> and that (I) (we) last saw the deceased alive on <i>1-21-70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sy Huh</i> M.D. DEGREE			23B. DATE SIGNED <i>1-21-70</i>		
23C. PHYSICIAN'S NAME (Type) <i>SOUNG YOUNG HUH</i> DEGREE			23D. ADDRESS <i>Mercy Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-23-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood CEMETERY</i>	
24D. LOCATION (City, town, or county) <i>BALTO, MD</i>		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>J. J. Galt</i>	
25D. ADDRESS <i>5444 BELAIR RD.</i>					

1872

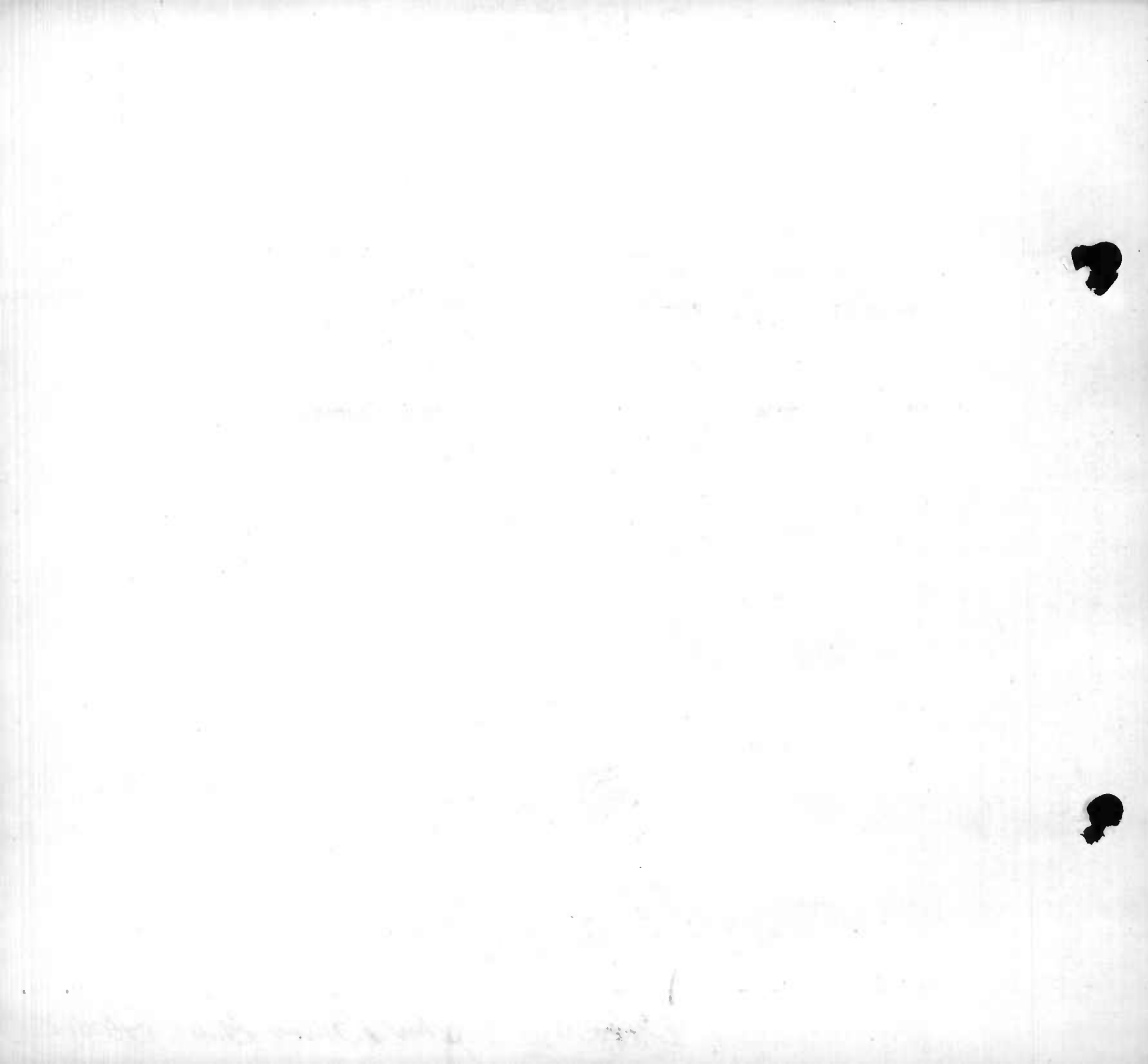
1872



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

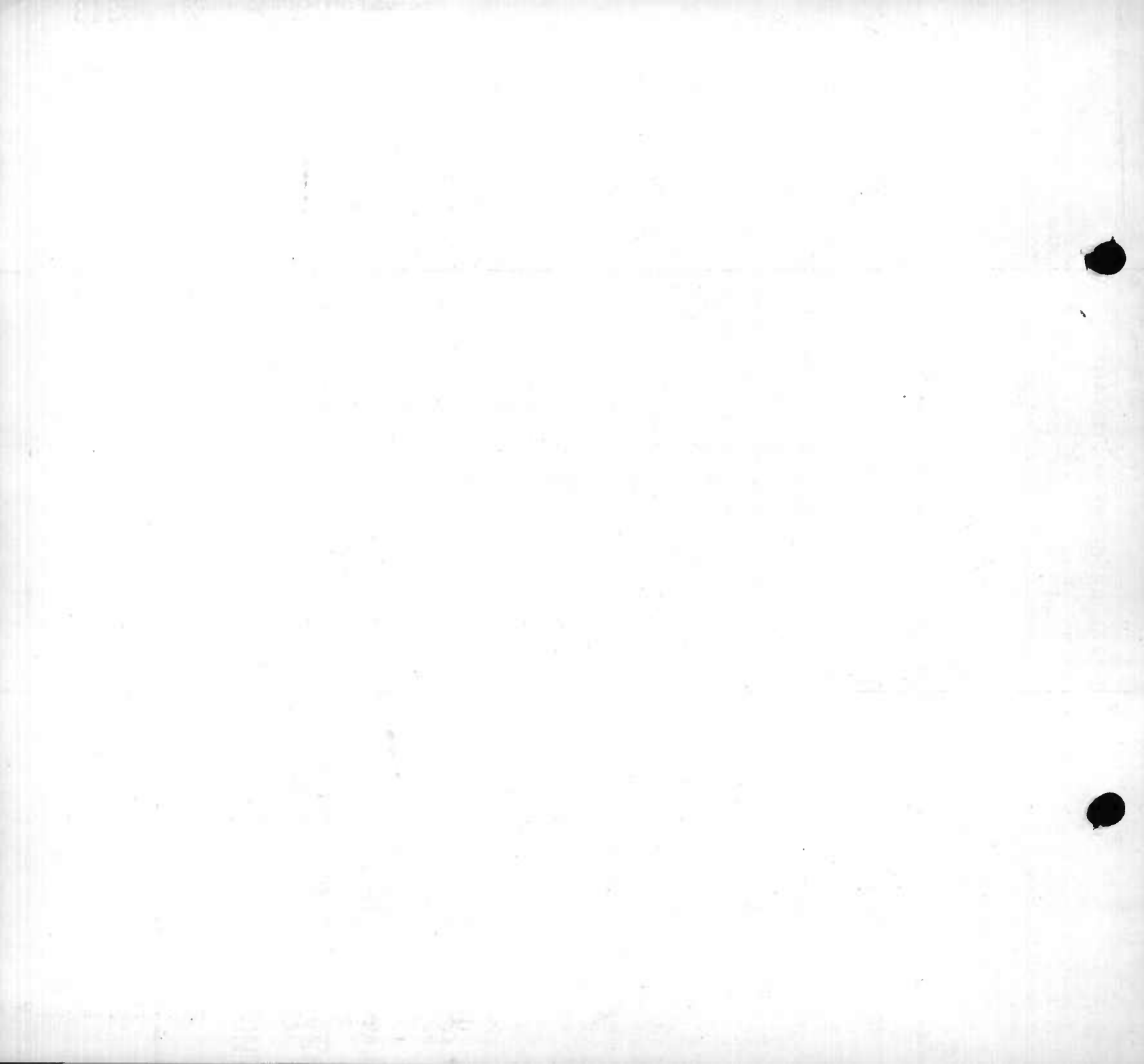
8-300		70 00942		BALTIMORE CITY HEALTH DEPARTMENT		70 00942	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Ann Louise Scott</i>				2. DATE AND HOUR OF DEATH <i>1-24-70</i> <i>2:30</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Key Circle Hospice</i>				C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>1214 Eutaw Place</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-19-77</i>	9. AGE (In years last birthday) <i>92</i>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own-home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Ferdinand Klepper</i>				14. MOTHER'S MAIDEN NAME <i>Alwinia Lange</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-01-6002</i>		17. INFORMANT <i>Family records</i>		ADDRESS	
15. none		16. none					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac failure today</i> <i>Chronic brain syndrome 5 yrs</i> <i>Generalized atherosclerosis 10 yrs</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 14</i> 19 <i>69</i> to <i>Jan 24</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>Jan 22</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type or Print) <i>RICHARD R. RIGLER</i>				23D. ADDRESS <i>1 W. Overlea Ave Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-27-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1970</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <i>[Signature]</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

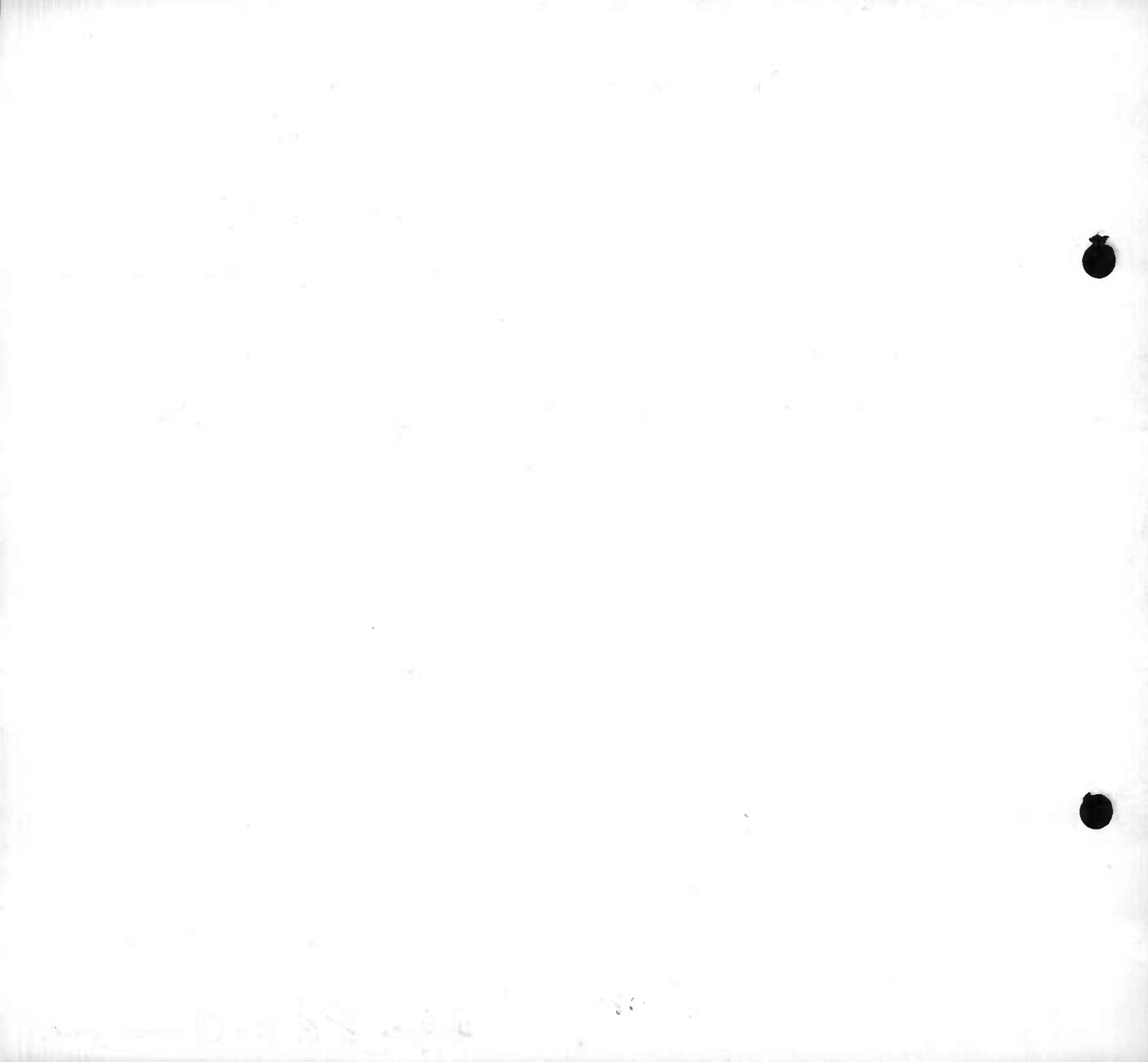
BALTIMORE CITY HEALTH DEPARTMENT									
70 00943									
70 00943									
REG. NO.									
<div style="display: flex; justify-content: space-between;"> <div> <p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>DR PHILIP F. Lerner</u></p> </div> <div> <p><b>2. DATE AND HOUR OF DEATH</b></p> <p><u>JAN 23, 1970</u>   <u>11<sup>20</sup></u> P. M.</p> </div> </div>									
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>003300 PINKNEY ROAD</u></p>					<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Maryland</u> 8. COUNTY <u>2440</u></p> <p>C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3300 Pinkney Rd</u></p>				
<p><b>5. SEX</b></p> <p><u>M</u></p>		<p><b>6. RACE</b></p> <p><u>W</u></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b></p> <p><u>July 23, 1906</u></p>		<p><b>9. AGE</b> (In years lost birthday) <u>64</u></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><u>Physician</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><u>Maryland</u></p>			<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><u>USA</u></p>		
<p><b>13. FATHER'S NAME</b></p> <p><u>Abraham</u></p>					<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><u>Hinda</u></p>				
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u></p>				<p><b>16. SOCIAL SECURITY NO.</b></p> <p><u>220-44-2307</u></p>		<p><b>17. INFORMANT</b></p> <p><u>Mrs Bess Lerner</u></p>		<p><b>ADDRESS</b></p> <p><u>Same</u></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p><u>ADENOCARCINOMA OF RIGHT LUNG</u></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>DIABETES MELLITUS</u></p>									
<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><u>7 MONTHS</u></p>									
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p><u>DIABETES MELLITUS</u></p>									
<p><b>19A. DATE OF OPERATION</b></p> <p><u>9/6/69</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p> <p><u>BIOPSY OF LUNG</u></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p><u>NO</u></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>			
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>				<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)</p>				<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>JUNE</u> <u>1969</u> <b>to</b> <u>JANUARY 23</u> <u>1970</u>, <b>that (I) (we) last saw the deceased alive on</b> <u>1-23</u> <u>1970</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>1-23</u> <u>1970</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>									
<p><b>23A. SIGNATURE</b></p> <p><u>Sean Ashman</u> M.D.</p>						<p><b>23B. DATE SIGNED</b></p> <p><u>1-24-70</u></p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><u>DEGREE</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><u>Burial</u></p>						<p><b>24B. DATE</b></p> <p><u>1/25/1970</u></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b></p> <p><u>Chapel Ameno</u></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><u>Balto</u> <u>Md</u></p>						<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><u>JAN 27 1970</u></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p><u>John E. Vandyke</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b></p> <p><u>Glynn Lerner &amp; Son, Inc</u></p>						<p><b>25D. ADDRESS</b></p> <p><u>9610 Reisterstown Rd</u></p>		<p><b>25E. ADDRESS</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

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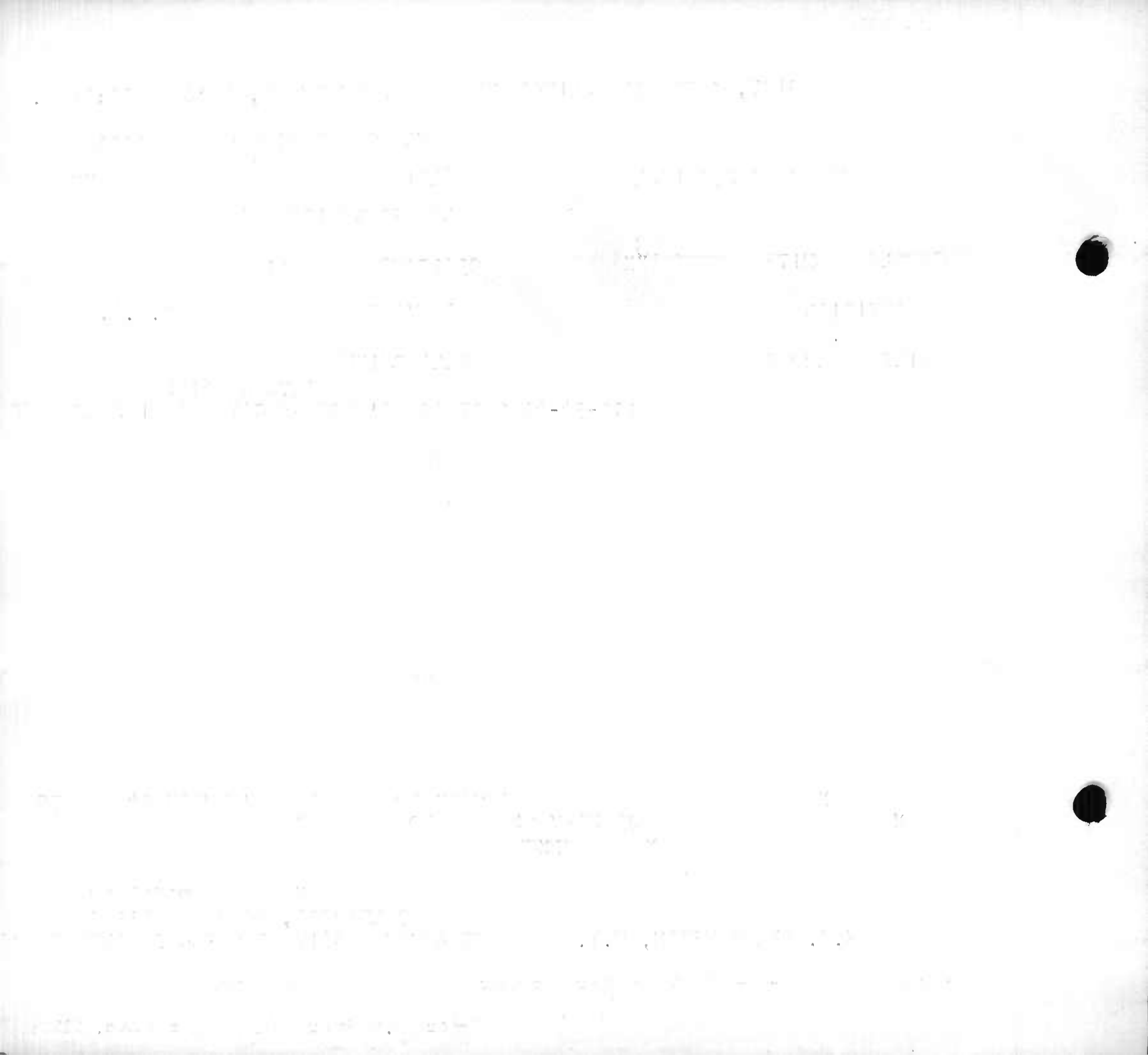
M-650		70 00944		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00944	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOSEPH MURRIN			
2. DATE AND HOUR OF DEATH 1/23/70 9:30 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2205 702			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 713 N. Belwood St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/01	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Clerk Crown Cook + seal		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph ? Murrin				14. MOTHER'S MAIDEN NAME Genevieve ? McAndrew			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 179-07-8668A		17. INFORMANT Mrs. Mary Murrin ADDRESS	
18. 199.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) metastatic carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/23/70 19 to 1/23/70 19 that (I) (we) last saw the deceased alive on 1/23/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George J. Berakha MD				23B. DATE SIGNED 1/23/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) GEORGE J. BERAKHA, MD				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/70		24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore 6 Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR Robert E. Fisher MD		25C. FUNERAL DIRECTOR		ADDRESS 1211 Chesapeake Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 00945</u>	
G-230 70 00945		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>GIST, KATHERINE ELIZABETH</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 24, 1970 12:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Catonsville</u> D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
<u>40</u>		E. STREET AND NUMBER <u>6308 FREDERICK ROAD</u> <u>53-00</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/15/88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>		9. AGE (In years last birthday) <u>81</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILTON ELMORE</u>		14. MOTHER'S MAIDEN NAME <u>ELLA SMITH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-34-4192</u>	
17. INFORMANT <u>BALTO MD 21229</u>		ADDRESS <u>ST AGNES RECORDS CATON &amp; WILKENS AVES</u>	
18. <u>427.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Constrictive Cardiac Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Edema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>JANUARY 20</u> 19 <u>70</u> to <u>JANUARY 24</u> 19 <u>70</u> that <u>(X)</u> (we) last saw the deceased alive on <u>JANUARY 24</u> 19 <u>70</u> and that in <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) <u>(X)</u> view the body after death.			
23A. SIGNATURE <u>M.G. Allen Mersh</u>		23B. DATE SIGNED <u>01/24/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.G. ALLEN MERSH, M.D.</u>		23D. ADDRESS <u>BALTIMORE, MARYLAND 21229</u> <u>ST AGNES HOSPITAL &amp; CATON &amp; WILKENS AVE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-27-1970</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	





# FUNERAL DIRECTOR: IMPORTANT

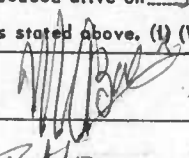
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

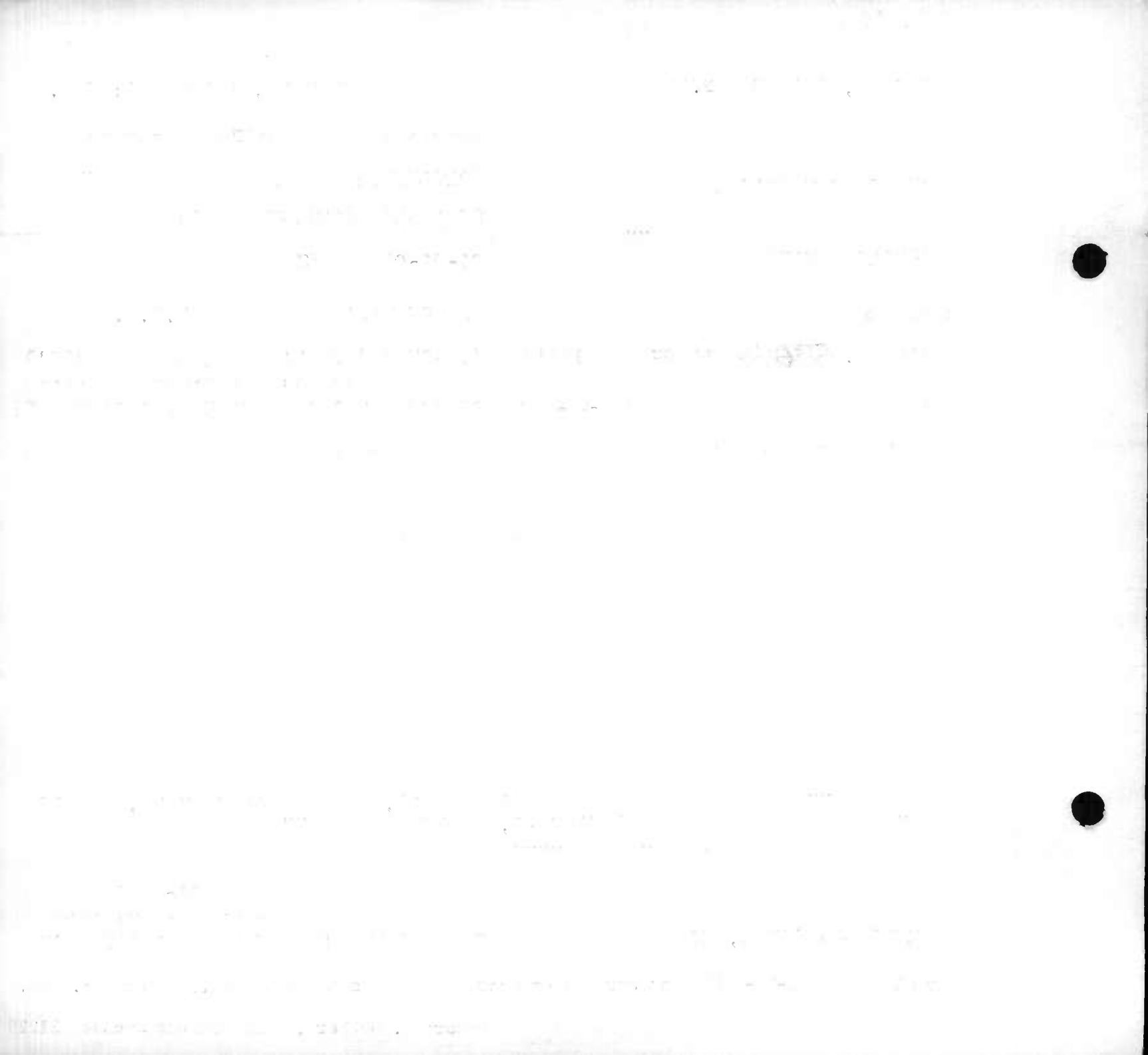
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
S-315		70 00946		70 00946	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MR ROLAND K. STEVENS		1/23/1970 0820 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
48 Maryland Gen. Hospital			Maryland XXXXXXXXXX 2533		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2357 Sidney Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White		3/3/1891	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired XXXXX			Maryland		US.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George B. Stevens			Ella Batchler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			218-01-0962		Mrs. Tenie Stevens, 2357 Sidney Ave. 21230
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
412.3 I			Ischemic (Hemorrhagic)		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-23 1970 to 1-23 1970 that (I) (we) last saw the deceased alive on 1-23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. S. AL-IBRAHIM M.D. DEGREE				1-23-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M.S. AL-IBRAHIM M.D. DEGREE				Md Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-26-70		Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 27 1970		Howard H. Hubbard		4107 Wilkens Ave. 21229	



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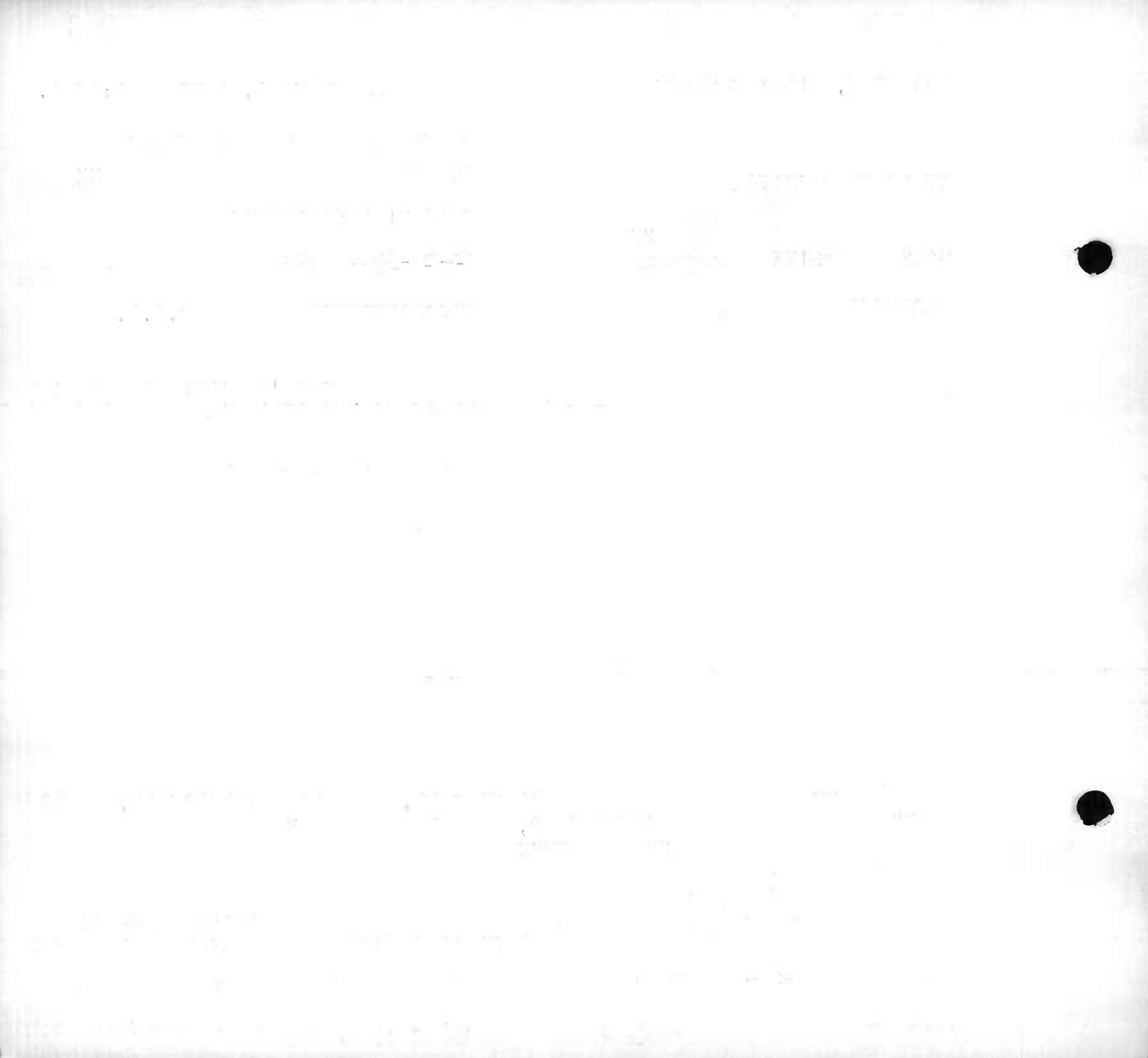
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00947
I-524 70 00947		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>INGELS, BLANCHE P.</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 23, 1970 3:25 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE ELKRIDGE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>6503 OLD WASHINGTON ROAD</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-03-08</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JOHN F. XXXXXXXX Heffner</b>		14. MOTHER'S MAIDEN NAME <b>(BENCHOFF) XXXXXXXX Virginia</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-22-1692</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>AC M.I.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>V. Fibrillation and Pump failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 24, 1969</b> to <b>JANUARY 23, 1970</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 23, 1970</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>01-23-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>MUHAMMAD A. FARID, MD</b>		23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-26-1970</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Washington Blvd., Howard Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>	25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	ADDRESS <b>4107 Wilkens Avenue 21229</b>	



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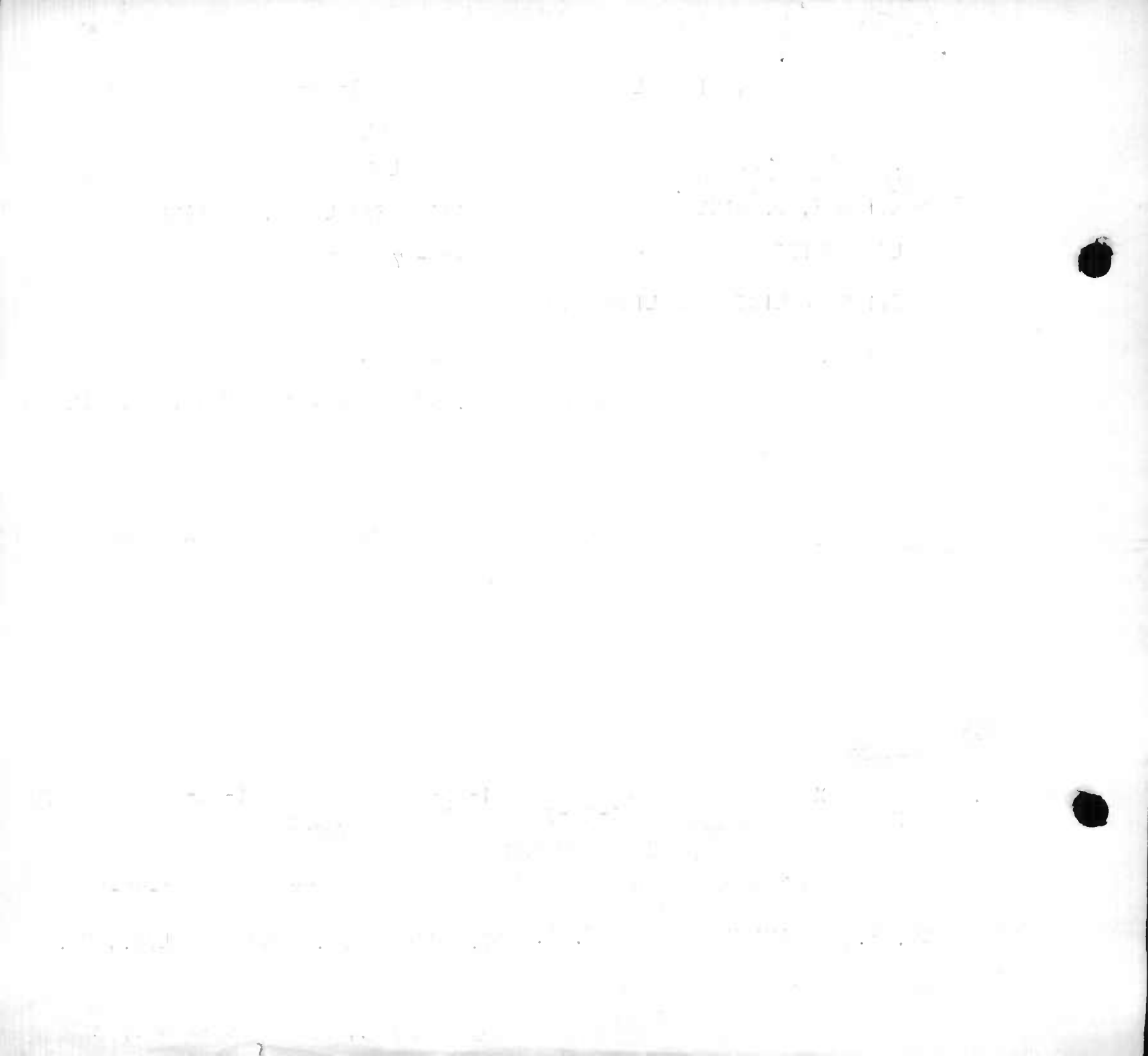
A-536 70 00948		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 00948	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANDERSON, WILLIAM HENRY		JANUARY 23, 1970 3:10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND HOWARD COUNTY 6300	
		C. CITY OR TOWN ELKRIDGE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 5820 VIRLONA AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1911	9. AGE (in years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 015-03-7206		17. INFORMANT RECORD 1'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE BRONCHITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE BRONCHITIS (B) DUE TO, OR AS A CONSEQUENCE OF: SEVERE BILAT PNEUMONIA (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (IX) (this hospital) attended the deceased from JANUARY 22, 19 70 to JANUARY 23, 19 70 that (IX) (we) lost saw the deceased alive on JANUARY 23, 19 70 and that in (IX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. AFZAL MD		23B. DATE SIGNED 1-23-70		23C. PHYSICIAN'S NAME (Type) M. AFZAL MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-1970		24C. NAME OF CEMETERY OR CREMATORY Grace Episcopal Cemetery	
24D. LOCATION Elkridge, Howard County, Md.		24E. NAME OF REGISTRAR Howard H. Hubbard		24F. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR 1-27-70		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

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H-150 70 00949		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 00949	
1. NAME OF DECEASED (Type or Print) <b>HOBAN, MICHAEL</b>			2. DATE AND HOUR OF DEATH <b>1-22-70 10:55A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSP. WILKENS &amp; CATON AVE. BALTIMORE, MD. 21228</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>MARYLAND</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1918 BEVERLY RD. 21228</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06-28-97</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED POLICE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>POLICE DEPT</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Patrick J. Hoban</b>			14. MOTHER'S MAIDEN NAME <b>Catherine M.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>220-44-9468</b>	17. INFORMANT ADDRESS <b>ST. AGNES RECORD ROOM CATON &amp; WILKENS</b>		
18. <b>441.2 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>(1) Ruptured Abdominal Aorta 3 hours</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(2) Aorta Aneurysm + Arteriosclerosis Cardiovascular years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>(c) disease</b>		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>1-22-70</b> to <b>1-22-70</b> that (X) (we) last saw the deceased alive on <b>1-22-70</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did <del>not</del> view the body after death.					
23A. SIGNATURE <b>Dr. B. Ebrahimi</b>			23B. DATE SIGNED <b>1-22-70</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. B. EBRAHIMI</b>
23D. ADDRESS <b>M. D. ST. AGNES HOSP. RECOR BALTO., MD.</b>			23E. DATE SIGNED <b>1-22-70</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/26/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>			
25A. NAME OF REGISTRAR <b>0000000000</b>		25B. FUNERAL DIRECTOR <b>0000000000</b>		25C. ADDRESS <b>0000000000, 1630 Edmondson Ave., 21228</b>	





**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ALMA JENKINS

2. DATE  
OF  
DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

January 17, 1970

M.

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

January 17, 1970

9:23 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

11. CO. 5200

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Pasadena

YES ☐ NO ☐

E. STREET AND NUMBER

7002 Ft. Smallwood Road

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

(DOA)

South Baltimore General Hospital

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10-15-06

10. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOHN WILKINS.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

CLARKIE WILKINS.

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Edward Macey 7002 Ft. Small Rd.

19. E815, 10

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple traumatic injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
highway

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Ree. #2 - Gov. Ritchie Highway.

22D. TIME OF INJURY (Approx.) 1-17-70 9:00 P.m.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR? (Anne Arundel County)  
Driver in auto-fixed object collision

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 18, 1970

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

1/24/70

24C. NAME of CEMETERY or CREMATORY

Marley Neck Church yd.

24D. LOCATION

(City, town, or county)

(State)

Anne Arundel county

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Isaiah L. Brown & son

ADDRESS

0232 W. Montgomery St. Balto., Md.

INSTITUTIONAL REPORT  
FACULTY EVALUATION STATEMENT

NAME

DATE

DEPARTMENT

POSITION

YEAR

MONTH

DAY

62

71

1. STATEMENT OF FACTS

2. ANALYSIS

3. CONCLUSIONS

4. RECOMMENDATIONS

5. COMMENTS

6. SIGNATURE

ACADEMIC BOARD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 70 00951				BALTIMORE CITY HEALTH DEPARTMENT		70 00951	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LOUISE BROWN</b>				2. DATE AND HOUR OF DEATH <b>1/17/70 12:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2102</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY OF MARYLAND HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>516 WYETH STREET</b>		21230	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/10</b>	9. AGE (in years last birthday) <b>59</b>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>LERoy BROWN</b>		ADDRESS <b>864 CARROLL ST.</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CIRRHOSIS &amp; INTRINSIC RENAL DISEASE</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> 19 <b>70</b> to <b>1/17</b> 19 <b>70</b> . that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Andrew M. Doyle</b>				23B. DATE SIGNED <b>1/17/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ANDREW M. DOYLE</b>				23D. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>I-21070</b>		24C. NAME of CEMETERY or CREMATORY <b>PHILPA</b>		24D. LOCATION (City, town, or county) (State) <b>PHILA. PA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>B. Brown</b>		ADDRESS <b>W. S.</b>	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
JOHN HENRY COLEMAN		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		January 17, 1970 6:45 A.M.		A. STATE Maryland B. COUNTY 2201	
117 W. Hill Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 10. AGE (In years lost birthday) 23		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Henry Coleman-Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Carrie Coleman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Carrie Coleman		ADDRESS 117 W. HILL ST					
19. 304.9		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Intravenous narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 18, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE I-22-70		24C. NAME OF CEMETERY or CREMATORY Mount Auburn		24D. LOCATION (City, town, or county) (State) Baltimore- City			
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR E. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Isaiah L. Brown & SON-105 W. Montgomery Street					

Letter from M.E.'s office

5-15-70

M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00953	
A-652 70 00953				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Armsstrong, Rossie</i>		2. DATE AND HOUR OF DEATH <i>1/16/70 9 PM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1703</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey St.</i> <i>Baltimore, Maryland</i>		E. STREET AND NUMBER <i>1338 Pennsylvania Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/26/94</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		11. BIRTHPLACE (State or foreign country) <i>unknown</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>218-05-7543</i>		17. INFORMANT <i>Rosie Wilson-1338- Penn Ave</i>	
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/31/69</i> 19 <i>70</i> to <i>1/16</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>1/16</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>1/16/70</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>1-23-7-</i>		<i>Mount Auburn</i>	
24D. LOCATION (City, town, or county)		24E. ADDRESS			
<i>Baltimore City</i>		<i>1338 Pennsylvania Ave.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. NAME OF FUNERAL HOME <i>Brown &amp; Sons</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

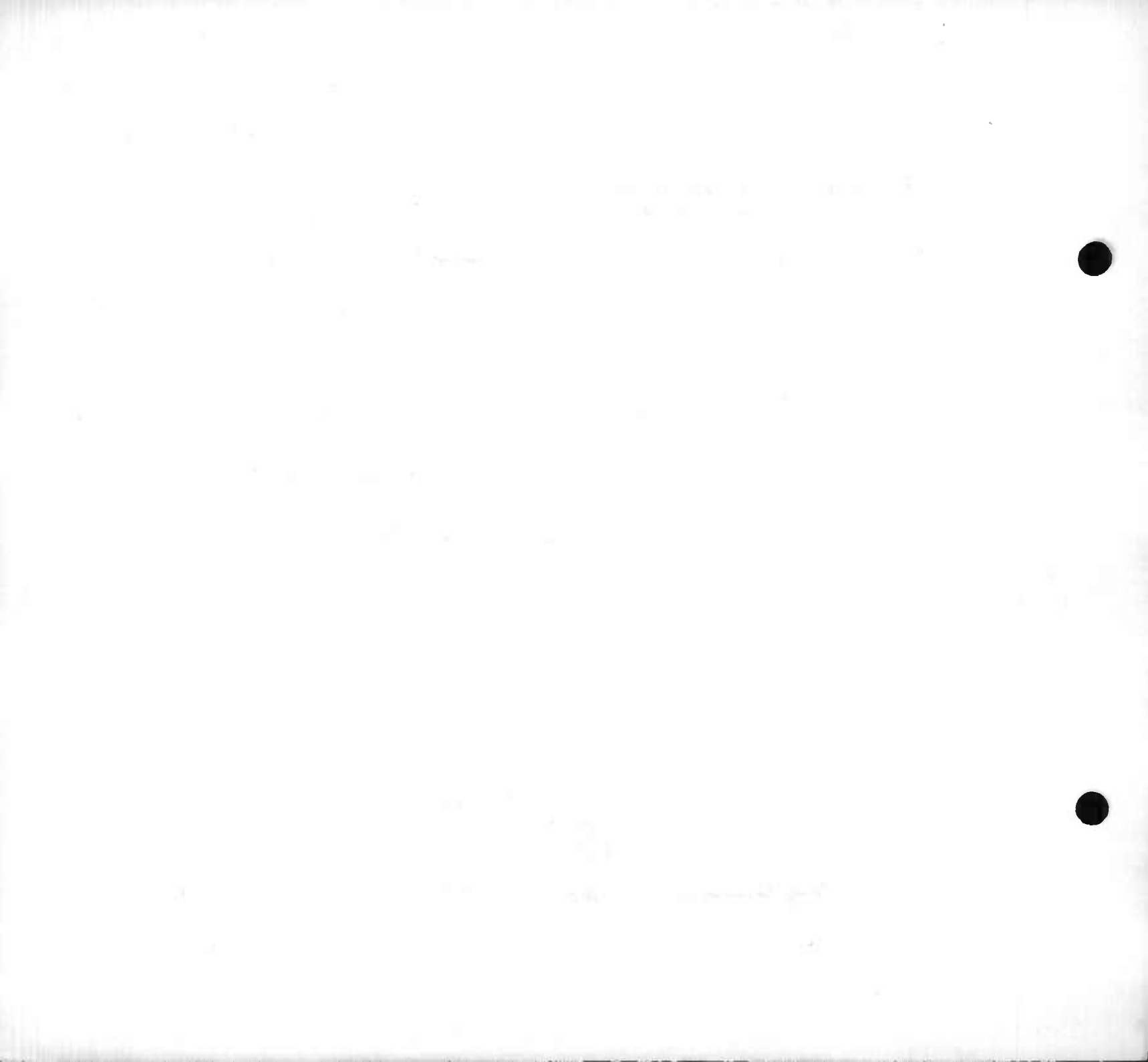
G-650		70 00954		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00954	
1. NAME OF DECEASED (Type or Print) <b>Louise GREEN</b>				2. DATE AND HOUR OF DEATH <b>1/25/70 4:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY 808</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1619 E. PRESTON STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-4-03</b>	9. AGE (In years last birthday) <b>66</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK (R) Soc. Sec.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>MD</b>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>NOAH JONES</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH PATTERSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-16-5456</b>		17. INFORMANT ADDRESS <b>ANNIE W. Golden 2862 Harford Ave</b>	
18. <b>135 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) <b>SARCROIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1/23</b> 19 <b>70</b> to <b>1/25</b> 19 <b>70</b> that (1) (we) last saw the deceased alive on <b>1/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James L. Bolen</b>				23B. DATE SIGNED <b>1/25/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JAMES L. BOLÉN</b>	
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>				23E. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>			
23F. NAME OF REGISTRAR <b>Joseph E. [unclear]</b>				23G. FUNERAL DIRECTOR <b>Joseph E. [unclear]</b>			
23H. ADDRESS <b>1304 N. Central Ave</b>				23I. DATE <b>1/29/70</b>			
23J. NAME OF CEMETERY OR CREMATORY <b>St. Calvary</b>				23K. LOCATION (City, town, or county) (State) <b>D. A. County, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

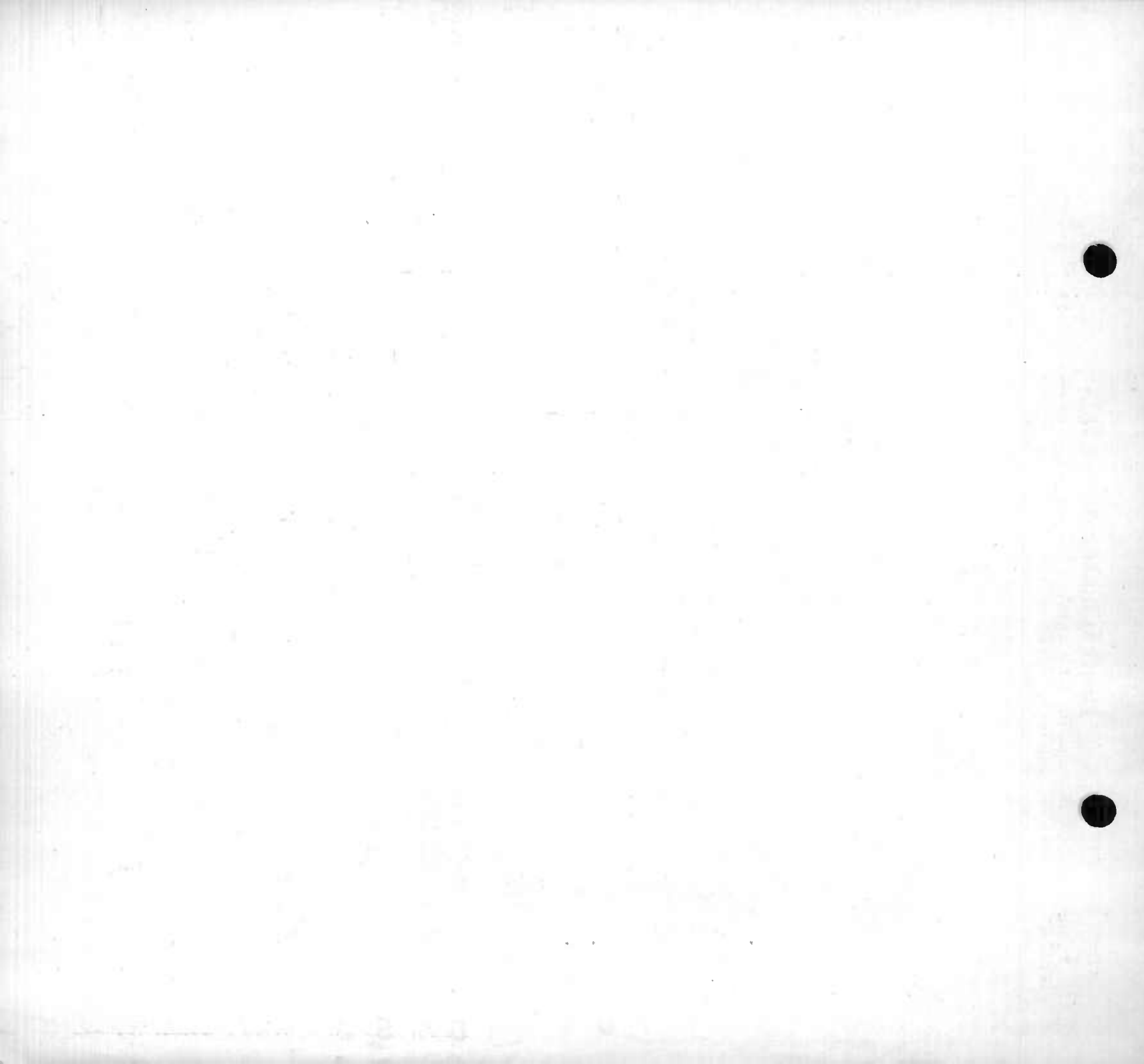
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-326		70 00955		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00955	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ERNEST WITCHER</b>				2. DATE AND HOUR OF DEATH <b>JAN 23 - 70</b>   <b>5 20 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>33 OSLER 3</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2046 ORLEANS STREET</b>		<b>21224</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-4-06</b>	9. AGE (in years last birthday) <b>63</b>	10. Under 1 Yr. Months Days   11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn Co Va</b>	
13. FATHER'S NAME <b>Tom Witcher</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Atkins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>233-02-3280</b>		17. INFORMANT <b>Nancy Jones</b> ADDRESS <b>Wash DC</b>	
18. <b>410.9</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CAUSE OF DEATH</b> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). (A) IMMEDIATE CAUSE <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 22</b> 19 <b>70</b> to <b>Jan 23</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Jan 23</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. Greg Brown</b> MD DEGREE				23B. DATE SIGNED <b>1/23/70</b>		23C. PHYSICIAN'S NAME (Type) <b>B. GREG BROWN</b>	
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Andy [Signature]</b>		ADDRESS <b>[Address]</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
J-525 70 00956 CERTIFICATE OF DEATH					REG. NO. 70 00956					
BIRTH NO.					1					
1. NAME OF DECEASED (Type or Print) <b>CHARLES JOHNSON</b>					2. DATE AND HOUR OF DEATH <b>JANUARY 25, 1970 11:20 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>806</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <b>1822 E. LAFAYETTE AVE</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-06-12</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>metal Works Labor</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				
13. FATHER'S NAME <b>WILLIAM JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE BURLEY</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>220</b>			16. SOCIAL SECURITY NO. <b>216-01-3100</b>		17. INFORMANT <b>Rosalene Johnson</b>		ADDRESS <b>same</b>			
18. <b>491 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTRA-CEREBRAL HEMORRHAGE</b> 3 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPOTENSIVE EPISODE w/ RESP. ARREST</b> 3 days <b>CHRONIC BRONCHITIS + EMPHYSEMA</b> 10 years										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypertensive Arteriosclerotic Cardiovascular Dis.</b> 10 years										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>JANUARY 19 1970</b> to <b>JANUARY 25 1970</b> , that (1) (we) last saw the deceased alive on <b>JANUARY 25 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Stephen C. Achuff</b> DEGREE					23B. DATE SIGNED <b>January 25, 1970</b>					
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN C. ACHUFF M.D.</b> DEGREE					23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS</b>		24D. LOCATION (City, town, or county) <b>Cat</b>		(State) <b>Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Yelley</b>			25C. FUNERAL DIRECTOR <b>George Wilson</b>			ADDRESS <b>1000 Country Club</b>	



BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DOROTHY HANSEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) <b>317 Duncan Street (South)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 24, 1970 11:30 A.</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>105</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 28, 1923</b>		10. AGE (In years last birthday) <b>46</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Leon Schmidt</b>		E. STREET AND NUMBER <b>317 Duncan Street (South)</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barmaid</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		15. MOTHER'S MAIDEN NAME <b>Agnes Chmielewski</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-14-9657</b>		18. INFORMANT ADDRESS <b>Mrs. Helen Sadler-2926 Lymond Place #21218</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carbon Monoxide Intoxication</b>		CAUSE OF DEATH <b>Carbon Monoxide Intoxication</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>317 Duncan Street (South) 105</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1-24-70 Unk.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Faulty heater</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/25/70</b>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/28/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Weber - 705 S. Ann St. #21231</b>	

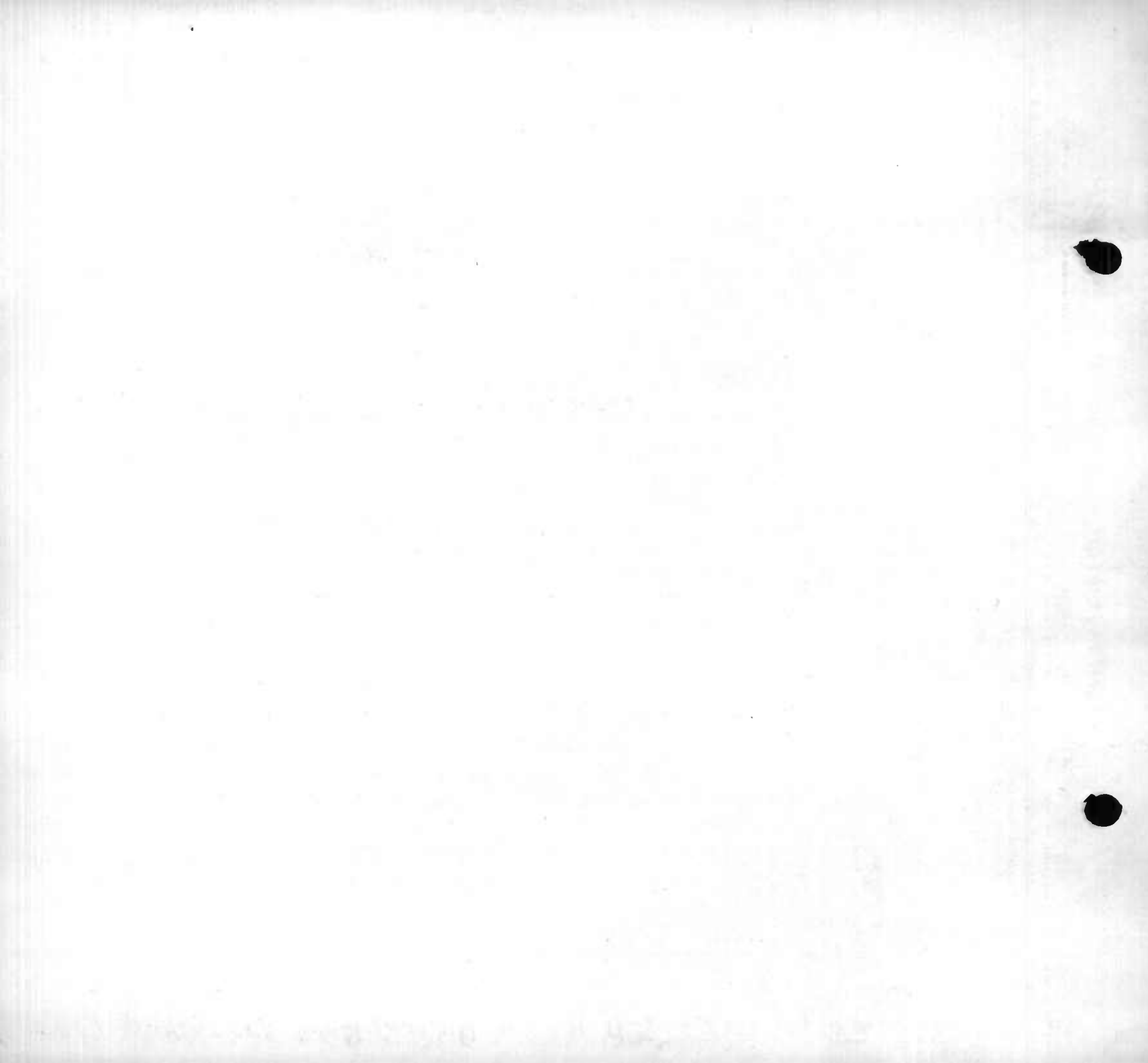
ACADEMY BOOK



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00958	
L-250		70 00958		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EUGENE M LOGAN</b>		2. DATE AND HOUR OF DEATH <b>1-25-70 4:46 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>909</b>		C. CITY OR TOWN <b>BALTO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEM. HOSPITAL</b> <b>BALTIMORE, Md.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1816 AIKEN ST.</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-1898</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NOT KNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>MA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peter Logan</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Harris</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>223-03-6817</b>		17. INFORMANT <b>Mrs Mary E. Logan 1816 Aiken St</b>	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH - HYPERTENSIVE CRISIS = MI?</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSIVE CV DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 mins.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 25 (3:55 PM) 1970</b> to <b>4:45 P.M. (1-25-70) 1970</b> , that (I) (we) last saw the deceased alive on <b>Jan. 25 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>[Signature]</b>	
23B. DATE SIGNED <b>1-25-70</b>		23C. PHYSICIAN'S NAME (Type) <b>N. M. CARMONA, M.D.</b>		23D. ADDRESS <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cern</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>DECEASED</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		25D. ADDRESS <b>928 E. North Ave</b>		25E. DATE <b>March 9 1970</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00959</u>	
BIRTH NO. <u>70 00959</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HELEN JOZWIAK</u>		2. DATE AND HOUR OF DEATH <u>1-25-1970</u> <u>8 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>602</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>GOULD CONV. HOME</u> <u>6116 BELAIR RD</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MACKOWIAK</u>		14. MOTHER'S MAIDEN NAME <u>SZYMANSKI</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-054101</u>		17. INFORMANT <u>STANLEY JOZWIAK 2308 MARCROFT RD</u>	
18. <u>412.4 + 1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cerebral Thrombosis</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes Mellitus</u>		CAUSE OF DEATH <u>Cerebral Thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio-Sclerotic Cerebro-Vascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Unknown</u> <u>Unknown</u>	
19A. DATE OF OPERATION <u>1-29-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>October 1</u> 19 <u>67</u> to <u>January 25</u> 19 <u>70</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>January 25</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Philibert Artigiani M.D.</u>		23B. DATE SIGNED <u>1/27/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Philibert Artigiani M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-29-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>		25B. NAME OF REGISTRAR <u>ROBERT J. JONES, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WEBER &amp; SONS INC</u>	
24D. LOCATION <u>DUNDALK MD.</u>		24E. ADDRESS <u>2305 Bayfield Ave. Baltimore Md.</u>			
24F. LOCATION (City, town, or county) (State)					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

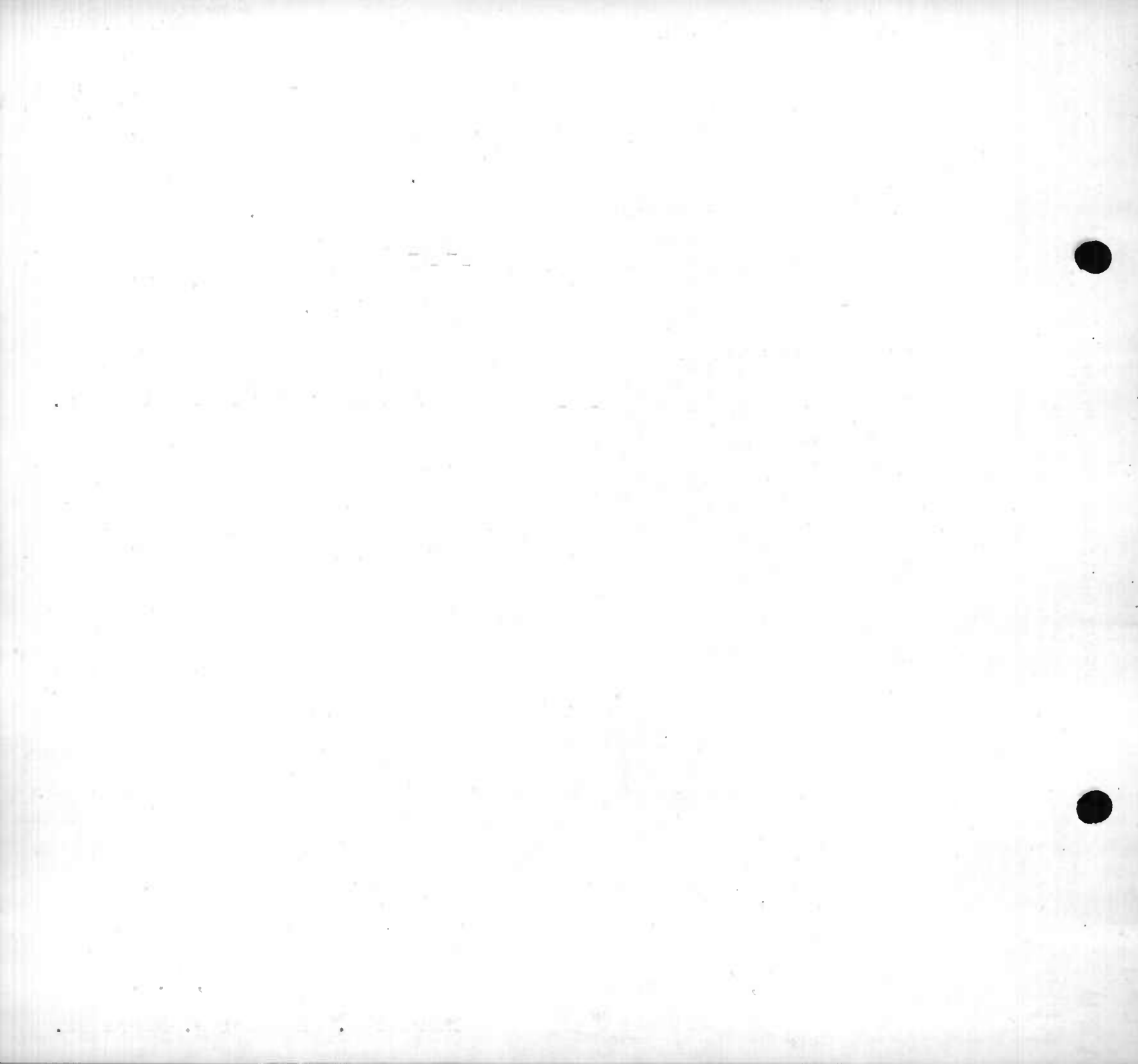
H-200		70 00960		CITY OF BALTIMORE		REG. NO. 70 00960	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <del>EDITH L. HAUGH</del> EDITH L. HAUGH			
2. DATE AND HOUR OF DEATH 1/24/70 1:35 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.				5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN BALTO.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 113 W. 42ND ST				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME JOHN TASE				14. MOTHER'S MAIDEN NAME MARTIE BOSLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-22-4122			
17. INFORMANT CHART Wesley Tase				ADDRESS 1113 W. 42ND ST.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: NASVD, CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 1/23/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/23/70 19 to 1/24 1970 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Harvey B. Sher M.D.			
23B. DATE SIGNED 1/24/70				23C. PHYSICIAN'S NAME (Type) HARVEY B. SHER M.D.			
23D. ADDRESS 40 UNION MEM. HOSP.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 1/28/70				24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			
24D. LOCATION Baltimore, Md.				25A. DATE RECD. BY HEALTH DEPT. JAN 27 1970			
25B. NAME OF REGISTRAR E. J. [illegible]				25C. FUNERAL DIRECTOR Anna Donovan			
25D. ADDRESS 3818 Roland Ave.							

VS 153 1-27-50  
X1H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <u>70 00961</u></p>	
<p><b>BIRTH NO.</b></p> <p><u>M-625 70 00961</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p><u>1-22-1970</u> <u>7:50</u> <u>A</u> M.</p>	
<p><b>1. NAME OF DECEASED</b></p> <p>(Type or Print) <u>Thomas Morrison</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>1512</u></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>90 Bolton Hill Nursing &amp; Convalescent Center</u></p>		<p>C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3454 Reisterstown Rd.</u></p>	
<p><b>5. SEX</b></p> <p><u>Male</u></p>	<p><b>6. RACE</b></p> <p><u>Negro</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b></p> <p><u>3-27-10</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><u>Farmer</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><u>Fayetteville, N. Carolina</u></p>	
<p><b>13. FATHER'S NAME</b></p> <p><u>Backus Morrison</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><u>USA</u></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p><u>243-14-6629</u></p>	
<p><b>17. INFORMANT</b></p> <p><u>Nannie Ross</u></p>		<p><b>ADDRESS</b></p> <p><u>3454 Reisterstown Rd.</u></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><u>412.2 I</u></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Hypertensive disease</u></p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>Arteriosclerosis gen</u></p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p><b>19A. DATE OF OPERATION</b></p> <p><u>0</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> 19<u>69</u> to <u>1/22</u> 19<u>70</u>, that (I) (we) last saw the deceased alive on <u>1/23</u> 19<u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b></p> <p><u>[Signature]</u></p>		<p><b>23B. DATE SIGNED</b></p> <p><u>1/23/70</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><u>ALLAN H. MALHOTRA MD</u></p>		<p><b>23D. ADDRESS</b></p> <p><u>2 E Real St Balto Md 21202</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><u>Burial</u></p>		<p><b>24B. DATE</b></p> <p><u>1/25/70</u></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b></p> <p><u>Fayetteville</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><u>Fayetteville, N.C.</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><u>JAN 27 1970</u></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p><u>Robert E. Taylor</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b></p> <p><u>Charles A. Rice</u></p>		<p><b>ADDRESS</b></p> <p><u>661 W. Barre St.</u></p>	





70 00962

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 00962

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CARRIE YOUNGBLOOD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 22 70 2:00 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>659 Barre St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 22, 1970 2:00 pm.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>9-30-16</b>		10. AGE (In years lost birth) <b>53</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Rosa Cole</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Willie Youngblood 659 W. Barre St.</b>	
19. CAUSE OF DEATH <b>412.7 + 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/23/70</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

RECEIVED BY MAIL - 1917

X

WILLIAMS PAPER CO.

*Chas. Williams*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00963</u>	
H-200 70 00963		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CHARLES HICKS</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 22, 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2562</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>903 Cherry hill Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>C.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/22/96</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Julia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		16. SOCIAL SECURITY NO. <b>114-12-3047</b>		17. INFORMANT ADDRESS <b>Mary Hicks 903 Cherry hill Rd.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1) MYOCARDIAL INFARCTION</b> (B) <b>ARTERIOSCLEROTIC C-V DIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/1/1966</b> to <b>1/22/1970</b> , that (I) (we) lost saw the deceased alive on <b>12/1/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John S. Braxton Jr.</b>		23B. DATE SIGNED <b>1/23/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON JR.</b>	
23D. ADDRESS <b>612 HILL VIEW RD. BALT. MD. 21215</b>		23E. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/26/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>Charles D. Rice</b>			
24F. FUNERAL DIRECTOR ADDRESS <b>661 W. Barre St.</b>		24G. DATE OF DEATH <b>1/22/70</b>			

1) MYSTICIAN INFORMATION

ANTHROPOLOGICAL C-V DIS

No.

1/11 01 5/11 01

James B. Brown Jr.

X

615 FIRE VIEW RD

1/23/70

1/23/70

P-625

70 00964

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 00964

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CRAIGE PEARSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>January 22, 1970</b>		Hour <b>XXXXXX</b> M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>730 Dover Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 22, 1970</b>		Hour <b>10:25 A.M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>2101</b>		
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>6-12-08</b>		10. AGE (in years last birthday) <b>61</b>	E. STREET AND NUMBER <b>730 Dover Street</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNK.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>UNK.</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>217-26-1219</b>		18. INFORMANT <b>Martha McFadden Lake City, S.C.</b>
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>January 22, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b> ADDRESS <b>661 W. Barre St.</b>

26/10/1964



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00965				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00965			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
(JOSEPH NICHOLAS HUBER) HUBER, JOSEPH				JANUARY 23 <sup>rd</sup> , 1970 3:30 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY					
UNION MEMORIAL HOSPITAL				MARYLAND		908					
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER							
				2302 GARRET AVENUE		21218					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.				
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	06-21-83	86							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)							
RETIRED				MARYLAND							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
MICHAEL L. HUBER				CATHERINE BAKER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.							
Yes SPANISH-AMERICAN				220-48-3677							
17. INFORMANT				ADDRESS							
BONITA REDMOND				same as above							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) subdural hemorrhage.							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) severe heart brachy pneumonia M.M.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				yes							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from JANUARY 19 1970 to JANUARY 23 1970 that (I) (we) lost saw the deceased alive on JANUARY 23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
J. Cabrera M.D.				JANUARY 23, 1970							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
J. CABRERA M.D.				UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		Jan. 27, 1970		Parkwood Cemetery		Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JAN 27 1970		Robert E. ...		HENRY SANDER & SONS, INC.		Baltimore Md.					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00966</u>
P-636 70 00966 BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <u>LOUISE PORTER</u>		2. DATE AND HOUR OF DEATH <u>1-26-70</u> <u>6:35 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1513</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL OF BALTO.</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2649 Loyola Southway</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/03</u>	9. AGE (In years last birthday) <u>66</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Miss.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John B. Eddins</u>		
14. MOTHER'S MAIDEN NAME <u>Everline</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Claudette Garner</u>		
18. <u>250.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO RESPIRATORY ARREST</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>LACTIC ACIDOSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES (on Phenformin)</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia -</u> <u>ASCVD with coronary insuff.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Terminal event</u> <u>8 days.</u> <u>24 days.</u> <u>5 days.</u> <u>YEARS</u>		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pneumonia -</u> <u>ASCVD with coronary insuff.</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (it) (this hospital) attended the deceased from <u>1-18-1970</u> to <u>1-26-1970</u> that (it) (we) last saw the deceased alive on <u>1-26-1970</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Alberto Angulo M.D.</u>		23B. DATE SIGNED <u>1-26-70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Alberto Angulo, M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/29/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Arbiter's Mon. Park</u>	24D. LOCATION (City, town, or county) (State) <u>Arbiter's, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	25C. FUNERAL DIRECTOR <u>Robert E. Fisher</u>	ADDRESS <u>1129 N. Caroline</u>	



L-230 70 00967

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 00967

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OLIVER LOCKETT

2. DATE AND HOUR OF DEATH

1-22-70 9 15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1502 North Regester Street 21213

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4/16/16

9. AGE (In years  
last birthday)

53

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rogers

14. MOTHER'S MAIDEN NAME

Elizabeth

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

193.3 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:SIGMOID  
CARCINOMA COLON

2 mo.

(C) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

1-12-70

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

CARCINOMA SIGMOID

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from Dec 13 19 69 to Jan 22 19 70,  
that (X) (we) last saw the deceased alive on JAN 20 19 70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Rolf H. Bessin M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

Jan 22 1970

23C. PHYSICIAN'S NAME (Type)

Rolf H. Bessin

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.  
2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/27/70

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem. 5501 Frederick Ave. Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1970

25B. NAME OF REGISTRAR

Rolf H. Bessin

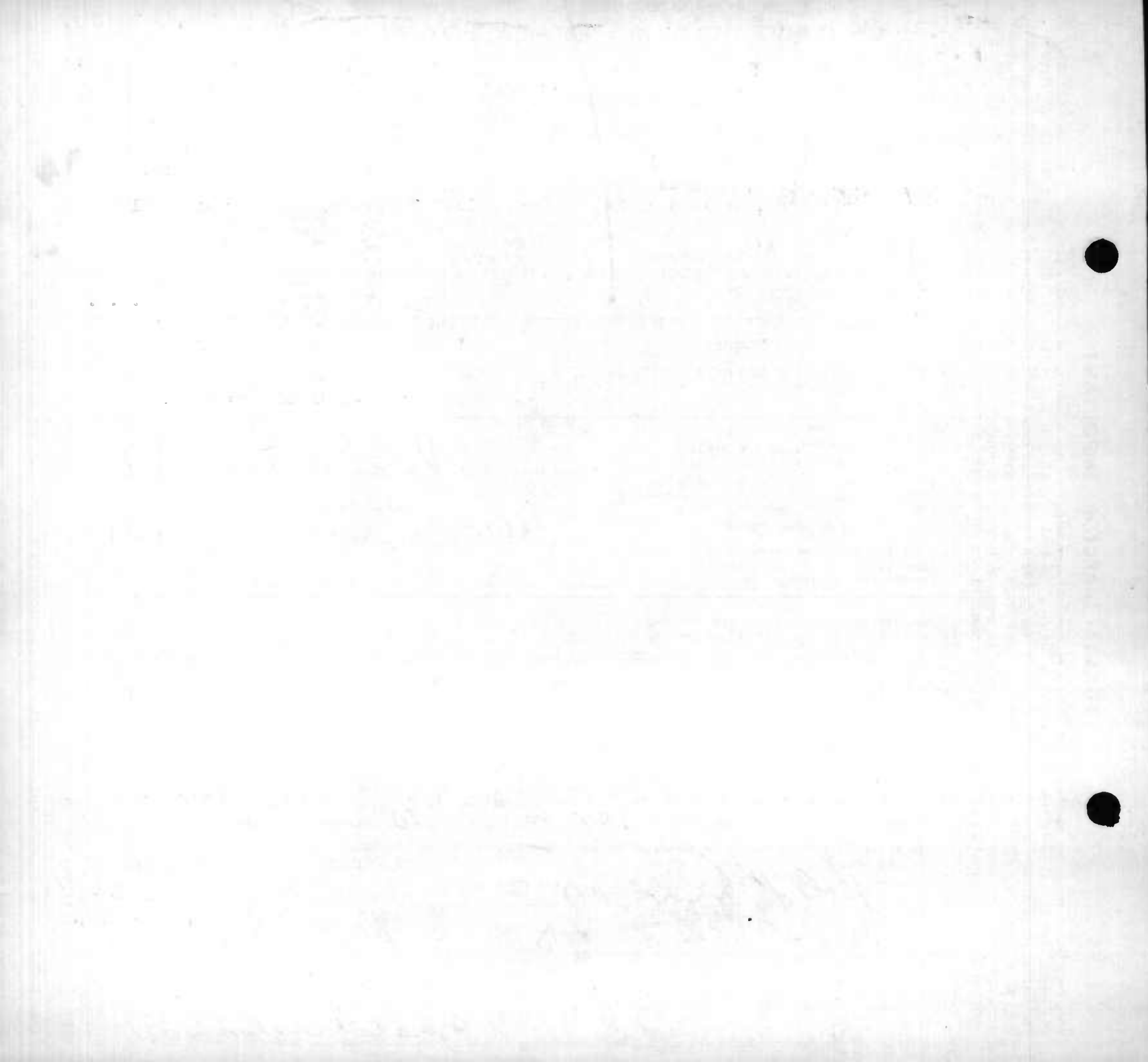
25C. FUNERAL DIRECTOR

Gerald L. Clicker 1/27/70

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600 70 00968		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 00968	
1. NAME OF DECEASED (Type or Print) <b>BEYER, HELEN</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 25, 1970 11:35A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> 21218 C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4518 MANORDENE RD.</b> 2864			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04 16 96</b>	9. AGE (in years last birthday) <b>73</b>	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK - RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THOMAS A. MITCHELL</b>				14. MOTHER'S MAIDEN NAME <b>MADELINE (DAVIS)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 18 0001</b>		17. INFORMANT <b>AVES. BALTO., MD.</b> ADDRESS <b>21229 ST. AGNES HOSP. RECORDS - CATON &amp; WILKENS</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema,</b> <b>C.H.F. &amp; C.V.A.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 20</b> 19 <b>70</b> to <b>JANUARY 25</b> 19 <b>70</b> that (X) (we) last saw the deceased alive on <b>JANUARY 25</b> 19 <b>70</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Veena Govila MD</b>				23B. DATE SIGNED <b>01 25 70</b>		23C. PHYSICIAN'S NAME (Type) <b>VEENA GOVILA M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>John E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>HON. Jenkins Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. Md. 21212</b>	

1941

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-620 70 00969				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 00969	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>JOHN W.E. FRECH</b>				2. DATE AND HOUR OF DEATH <b>1/26/70 12<sup>30</sup> P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>831</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2400 ERMAN AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3/25/00</b>		9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jeweler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO ATLANTA, GA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. FRECH</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE NOT KNOWN EMBSHOFF</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-4558</b>		17. INFORMANT <b>MRS. JOAN STONE SIFER</b> ADDRESS <b>(DAUGHTER) (SAME)</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>185 X I</b> <b>CARDIO-RESPIRATORY FAILURE</b> DUE TO <b>METASTATIC CA OF PROSTATE</b> DUE TO <b>HEMOLYTIC ANEMIA - TYPE UNDETERMINED</b>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>1/19/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA OF PROSTATE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/1/70</u> 19 to <u>1/26/70</u> 19, that (I) <u>(we)</u> last saw the deceased alive on <u>1/26/70</u> 19 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <b>J. Oldroyd M.D.</b>				23B. DATE SIGNED <b>1/26/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN LAY OLDROYD M.D.</b>	
24A. BURIAL (CREMATION, REMOVAL (Specify)) <b>Burial</b>		24B. DATE <b>1/29/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>27 1970</b>		25B. NAME OF REGISTRAR <b>22 7 0 0 0</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins</b> ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-630		70 00970		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 70 00970	
BIRTH NO.		M.E. CASE NO.				2	
1. NAME OF DECEASED (Type or Print) <b>Joseph M. Truitt</b>				2. DATE AND HOUR OF DEATH <b>1/26/70 11:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital Baltimore, Maryland</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>2631</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b>			
				D. STREET ADDRESS (If rural, give location) <b>4406 White Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>10/23/89</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESMAN MODERN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>APPLIANCE</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN Franklin Truitt</b>		14. MOTHER'S MAIDEN NAME <b>Mary Marsh</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>213-01-1236</b>		17. INFORMANT ADDRESS <b>Mrs. GENEVIEVE C. TRUITT (SAME)</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>517.21-173.9</b>				CAUSE OF DEATH (A) <b>Bronchopneumonia</b> DUE TO (B) <b>COPD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>Many years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>1/19/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Basal cell epithelioma</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> 19 <b>70</b> to <b>1/26</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stuart V. Grandis</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stuart V. Grandis</b>				23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/28/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Slaughter Neck</b>		24D. LOCATION (City, town, or county) (State) <b>Milford Delaware</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>James W. Jenkins</b>		25D. ADDRESS <b>Balto. 21212 York Rd</b>	

10/18/84 80  
Male Case, Maryland  
Baltimore, Maryland

NSA  
North March  
The House  
Franklin Trust

212-41-1550 10-11-84

Interagency

COLD

11/15/84 - 11/15/84

11/15/84 11/15/84

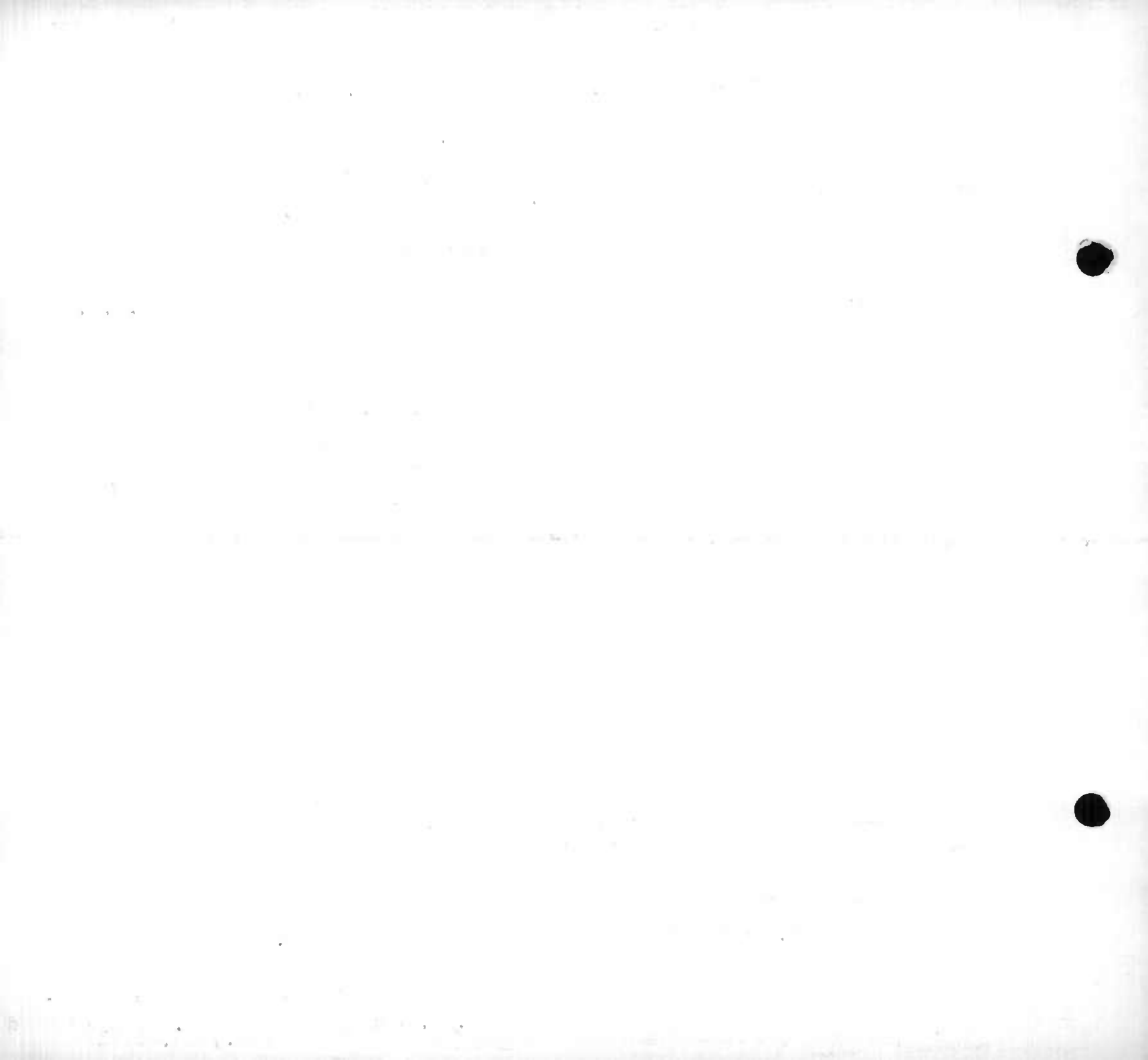
Frank V. Gromb  
Frank V. Gromb

11/15/84  
Maryland General

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

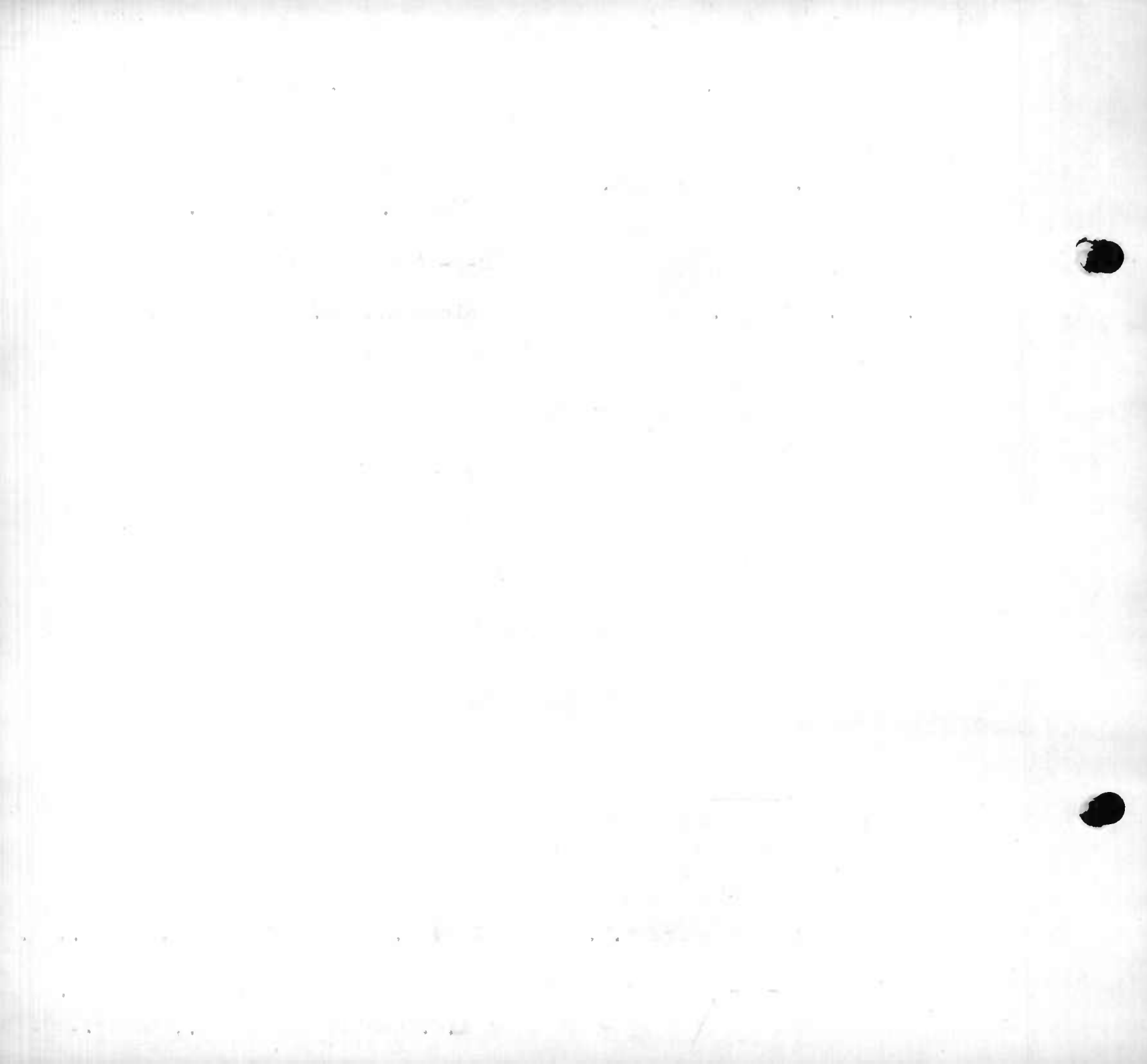
B-626		70 00971		BALTIMORE CITY HEALTH DEPARTMENT		70 00971	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Minnie E. Burkhard				Jan. 23, 1970 12:50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Gould Convalesarium - Belair Rd.				Md.			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore 21218		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				739 McKewin Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/14/1876	93			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Own Home		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Openshaw				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Raymond A. Burkhard (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				5y			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Artisanal death CVD			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4 PM 19 62 to 23 Jan 19 70 that (I) (we) last saw the deceased alive on 16 Jan 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Howard Goodman				26 Jan 70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				8604 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/26/70		Parkwood		Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 27 1970		Robert E. Jenkins		H. W. Jenkins & Sons Co.		4905 York Rd. Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

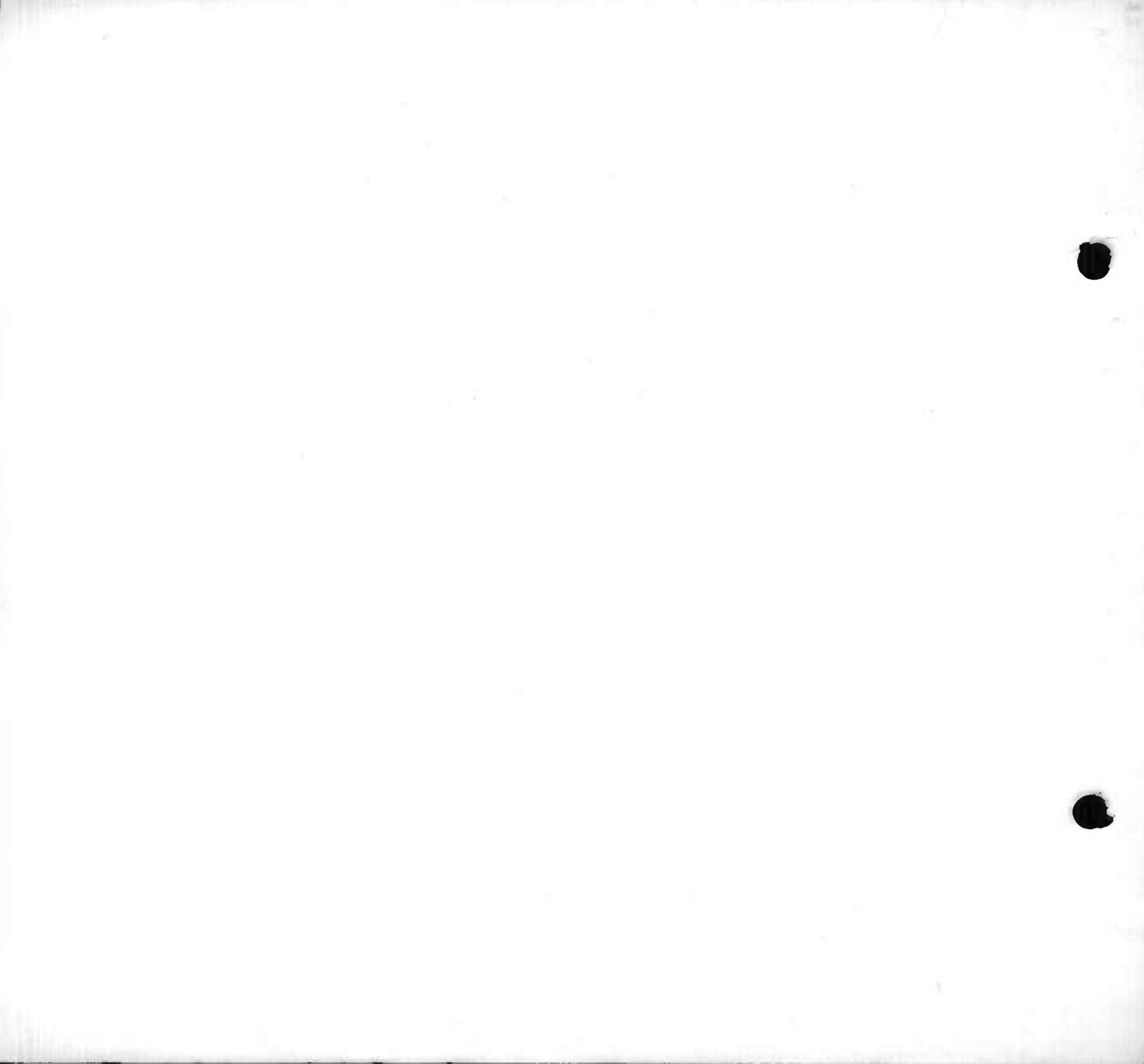
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00972	
L-300 70 00972				CERTIFICATE OF DEATH	
BIRTH NO.				1. NAME OF DECEASED	
(Type or Print)				ARTHUR A. LOTH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Jan. 23, 1970 6 P. M.	
1125 E. Belvedere Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
00				A. STATE Maryland	
				B. COUNTY 2748	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1125 E. Belvedere Ave.	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-3-1884		9. AGE (In years lost birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
				11. BIRTHPLACE (State or foreign country) Richmond, Va.	
				12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME	
Ret. Acct. Off Mgr.				Charles Loth	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Wilhelmenia Guvernator		No		212-01-2816A	
17. INFORMANT		18. CAUSE OF DEATH		ADDRESS	
Gertrude Loth				Same	
		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		5 days	
		ANTECEDENT CAUSES		10 days	
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		5 yrs.	
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Generalized Arterio Sclerosis	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug. 2 - 1968 to Jan. 23 - 1970, that (I) (we) last saw the deceased alive on Jan. 22nd 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Earl L. Chambers M.D.				1/24/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Earl L. Chambers M.D.				1000 W. Cold Spring Lane, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-26-70		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 27 1970		Earl L. Chambers, M.D.		W. Jenkins & Sons Co., Balto., Md.	
				4905 York Rd. 21212	



THE BODY OF WILLIAM VAUGHN HAS BEEN RELEASED AS NONMED BY 22 91 RS  
 MAJOR OF THE MEDICAL EXAMINER'S OFFICE  
 DR D. F. VAUGHN, WILLIAM  
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00973	
V-250 70 00973					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Vaughn		2. DATE AND HOUR OF DEATH JAN. 23, 1970 10:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 1015 QUANTRIL WAY 2634		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION JOHN'S HOPKINS HOSPITAL 601 N. BROADWAY		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-2-17		9. AGE (in years last birthday) 52		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL mine WORKER		10B. KIND OF BUSINESS OR INDUSTRY COAL		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U-S.		13. FATHER'S NAME William S. Bond. Vaughn		14. MOTHER'S MAIDEN NAME Maxine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 227-24-8462		17. INFORMANT Mollie J. Vaughn Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C.V.A. - large intracerebral hematoma + T.B.P.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) probable ASCVD + vasculitis (S.L.E.) DUE TO, OR AS A CONSEQUENCE OF:		20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). D.M., seizure disorder, old M.I., chronic ethanolism, S.L.E.					
19A. DATE OF OPERATION 1-21-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (B) frontal intracerebral hematoma		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1-21 1970 to 1-23 1970 that (I) (we) last saw the deceased alive on 1-21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE STEPHEN D. ROSENBAUM		23B. DATE SIGNED 1-23-70			
23C. PHYSICIAN'S NAME (Type) STEPHEN D. ROSENBAUM		23D. ADDRESS 601 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-27-70		24C. NAME of CEMETERY or CREMATORY VAUGHN	
24D. LOCATION DUFFIELD		24E. CITY, town, or county VA.		24F. STATE VA.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 27 1970		25B. NAME of REGISTRAR H.W. JENKINS & Sons Co.		25C. FUNERAL DIRECTOR BALTO, MD	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">P-412</span>					REG. NO. <span style="float: right;">70 00974</span>				
1. NAME OF DECEASED (Type or Print) <b>LE ROY M. POLVOGT M.D.</b>					2. DATE AND HOUR OF DEATH <b>1-23-70 9:15 PM</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>21152</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <b>Glencoe rural</b>									
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-96</b>	9. AGE (in years last birthday) <b>73</b>	10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Phys. Surgeon</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins Hosp.</b>			11. BIRTHPLACE (State or foreign country) <b>Wilmington, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CARL POLVOGT</b>			14. MOTHER'S MAIDEN NAME <b>MARY A. Leismen</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>579-38-9767</b>		17. INFORMANT <b>Esther Polvogt</b>		ADDRESS <b>Same</b>		
18. CAUSE OF DEATH <b>412.4 + 1250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <b>MYOCARDIAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>? CVA</b> (B) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>DIABETES</b> <b>PROBABLE SMALL BOWEL INFARCTION</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>									
19A. DATE OF OPERATION <b>JAN 14, 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABD PAIN</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NA</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>					
21D. TIME OF INJURY (APPROX.) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <b>NA</b> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NA</b>					
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>JAN 14</b> 19 <b>70</b> to <b>JAN 23</b> 19 <b>70</b> that <b>(I)</b> <b>(we)</b> last saw the deceased alive on <b>JAN 23</b> 19 <b>70</b> and that in <b>(my)</b> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above <b>(I)</b> <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death.									
23A. SIGNATURE <b>Vernon Tolo M.D.</b>					23B. DATE SIGNED <b>January 23, 1970</b>				
23C. PHYSICIAN'S NAME (Type) <b>VERNON TOLO</b>					23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glencoe, Immanuel</b>		24D. LOCATION (City, town, or county) (State) <b>Glencoe Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howe Jenkins Sons Co.</b> ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>					

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Johns Hopkins Hosp. Wilmington, N. C.

W. Surgeon

A. Leisner

Esther Polver

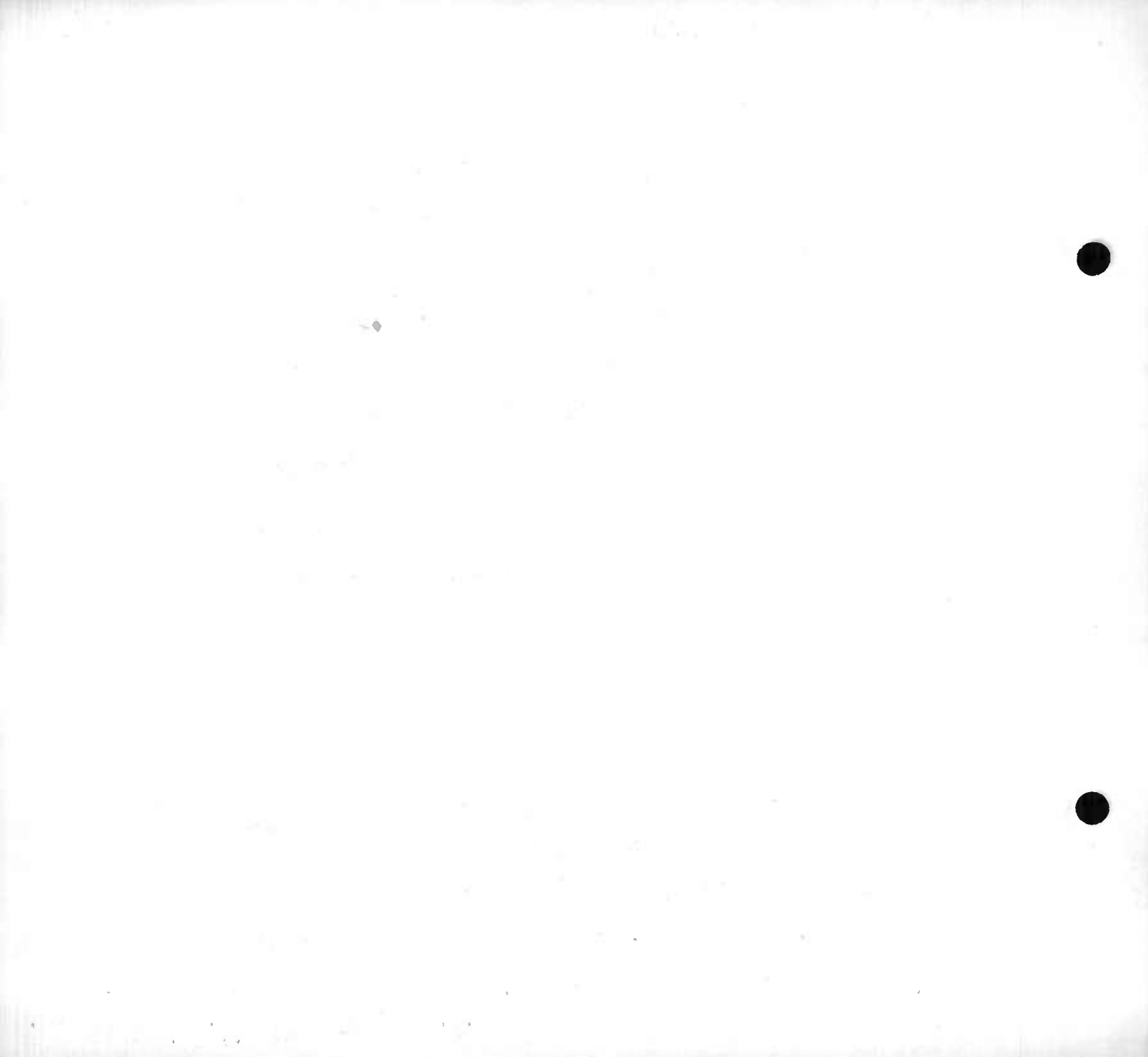
579-38-2767

No.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 00975</u>
BIRTH NO. <u>H-500</u>		70 00975		
1. NAME OF DECEASED (Type or Print) <u>Effie E. Haynie</u>		2. DATE AND HOUR OF DEATH <u>1-25-70</u> <u>5:20</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> <u>Baltimore Md. 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1201</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>6 N. HADLEY Sq. N.</u> <u>21218</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-82</u>	9. AGE (In years last birthday) <u>87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Reedsville, Va.</u>
13. FATHER'S NAME <u>Elvis W. Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Judith C. McShelley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>26-46-7242</u>		17. INFORMANT <u>Allen Haynie</u> ADDRESS <u>6403 Pinehurst Road</u>
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> <u>6 hours</u>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Thrombosis</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>due to Coronary Atherosclerosis</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19 1945</u> to <u>Jan. 25 1970</u> that (I) <u>last</u> saw the deceased alive on <u>January 25 1970</u> and that (in my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.				
23A. SIGNATURE <u>Katherine H. Borkovich M.D.</u>		23B. DATE SIGNED <u>1-25-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Katherine H. Borkovich</u>		23D. ADDRESS <u>550 N. Broadway-Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>1/27/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Roseland Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Reedsville, Va.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>		25B. NAME OF REGISTRAR <u>Valerie E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H. J. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 00976</span>	
W-426 70 00976		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Juliet T. Walker</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center;">Jan. 25, 1970</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">200 M.</span> B. COUNTY <div style="text-align: center;">Maryland</div>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">Long Green Nursing Home</div>		C. CITY OR TOWN <div style="text-align: center;">Baltimore</div>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> *** NO <input type="checkbox"/>	
5. SEX <div style="text-align: center;">F</div>		6. RACE <div style="text-align: center;">W</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Housewife</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Own Home</div>		8. DATE OF BIRTH <div style="text-align: center;">3-4-1886</div>	
13. FATHER'S NAME <div style="text-align: center;">Benjamin H. Tyson</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Virginia Cabell</div>		9. AGE (in years last birthday) <div style="text-align: center;">83</div>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center;">No</div>		16. SOCIAL SECURITY NO.		17. INFORMANT <div style="text-align: center;">Mr. Julian Marshall</div>	
18. <span style="font-size: 1.5em;">440.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center;">ANTECEDENT CAUSES</div> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="text-align: center;">Congestive Heart Failure</div> (B) <div style="text-align: center;">Arteriosclerosis</div> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">7 day</div> <div style="text-align: center;">3 yrs.</div>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <div style="text-align: center;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <div style="text-align: center;">No</div>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <div style="text-align: center;">Nov 1955</div> to <div style="text-align: center;">25 Jan 1970</div> that (I) ( <del>we</del> ) last saw the deceased alive on <div style="text-align: center;">15 Jan 1970</div> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <div style="text-align: center;">Dr. William G. Helfrich</div>				23B. DATE SIGNED <div style="text-align: center;">1-27-70</div>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <div style="text-align: center;">5006 Roland Avenue</div>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		24B. DATE <div style="text-align: center;">1-28-70</div>		24C. NAME of CEMETERY or CREMATORY <div style="text-align: center;">Greenmount</div>	
24D. LOCATION <div style="text-align: center;">Baltimore,</div>		24E. (City, town, or county)		24F. (State) <div style="text-align: center;">Md.</div>	
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center;">JAN 27 1970</div>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <div style="text-align: center;">H. W. Jenkins &amp; Sons Co.</div>	
				ADDRESS <div style="text-align: center;">4905 York Road Balto., Md. 21212</div>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 00977					REG. NO. 70 00977				
BIRTH NO. <u>H-208</u>					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Alphonse William Hayes</u>					2. DATE AND HOUR OF DEATH <u>1-25-70</u> <u>7:40 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Union Memorial Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2710</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>519 Oakland Ave</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08-02-97</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months Days		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. BARTENDER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>GORDON-MURRAY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Hayes</u>					14. MOTHER'S MAIDEN NAME <u>Janie Carens</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI ARMY</u>			16. SOCIAL SECURITY NO. <u>212-05-3671</u>		17. INFORMANT <u>(Hospital Chart)</u>			ADDRESS	
18. <u>5699 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>acute GI bleed</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>12-13-69</u> to <u>1-25-70</u> that (1) (we) last saw the deceased alive on <u>1-25-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.									
23A. SIGNATURE <u>M. Cepeda M.D.</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-25-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Cepeda M.D.</u>					23D. ADDRESS <u>Union Memorial Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-28-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) <u>Balto., Co.</u>		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>How. Jenkins &amp; Sons Co.</u>				
ADDRESS <u>4905 York Rd. Balto. Md. 21212</u>									

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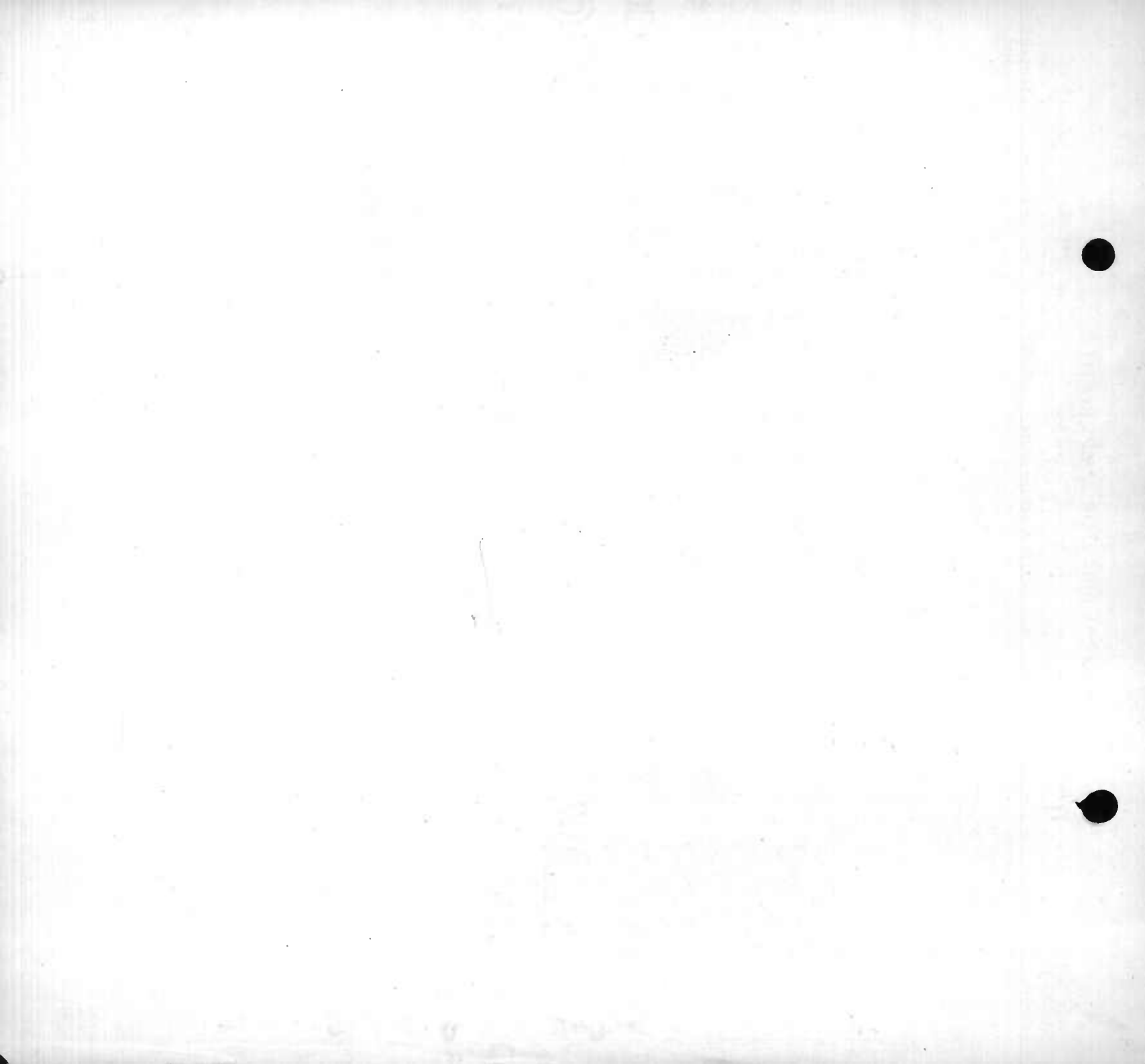
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00978
BIRTH NO. 70 00978		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>DRYMALA, JOSEPH S. (Drzymala)</b>		2. DATE AND HOUR OF DEATH <b>1-25-1970 5:30 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND 730 ASH BURTON STREET BALTIMORE, MD. 21216</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2401</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1632 E. FORT AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-1913</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Cargo Loading</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Simon Drymala (Drzymala)</b>		
14. MOTHER'S MAIDEN NAME <b>Maryanna Marda</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		
16. SOCIAL SECURITY NO. <b>217-01-5676</b>		17. INFORMANT <b>Mrs. Cecilia Drymala, 1632 E. Fort Ave</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>I</b> <b>HEPATIC COMA</b> <b>CIRRHOSIS OF LIVER</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12-1-1969</b> to <b>1-25-1970</b> , that (I) (we) last saw the deceased alive on <b>1-25-1970</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Prem Lal M.B.B.S.</b>		23B. DATE SIGNED <b>1-25-1970</b>		23C. PHYSICIAN'S NAME (Type) <b>PREM LAL M.B.B.S.</b>
23D. ADDRESS <b>LUTHERAN HOSPITAL 730 ASH BURTON ST. BALTIMORE MD. 21216</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/28/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Mem. Gardens</b>	24D. LOCATION (City, town, or county) (State) <b>Cockeysville, Md. 21030</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1970</b>	25B. NAME OF REGISTRAR <b>Roger J. [unclear]</b>	25C. FUNERAL DIRECTOR ADDRESS <b>M.F. GADWOSKI &amp; SONS, 1808 EASTERN AVE</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00979</u>
BIRTH NO. <u>70 00979</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>EDWARD BARTKOWSKI</u>		2. DATE AND HOUR OF DEATH <u>1-25-70</u> <u>1:50 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 CHURCH HOME &amp; HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>201</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>231 S. CASTLE ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-04</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MICHAEL BARTKOWSKI</u>		
14. MOTHER'S MAIDEN NAME <u>MARY ANN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-10 4540</u>		17. INFORMANT <u>IDA BARTKOWSKI</u> ADDRESS <u>231 S. CASTLE ST.</u>		
18. <u>426 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>(A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF:  <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u>  <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CONSTRICTIVE PERICARDITIS?</u> <u>ASCVD &amp; CONSTRICTIVE HEART FAILURE</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>(Month) (Day) (Year) (Hour)</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> 19 <u>69</u> to <u>1-25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>		23B. DATE SIGNED <u>1-25-70</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>
23D. ADDRESS <u>Church Home &amp; Hosp. 100 N. Broadway</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>1/29/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber, MD.</u>		25C. FUNERAL DIRECTOR <u>M. P. Sadowski &amp; SONS, 1808 EASTERN AVE</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

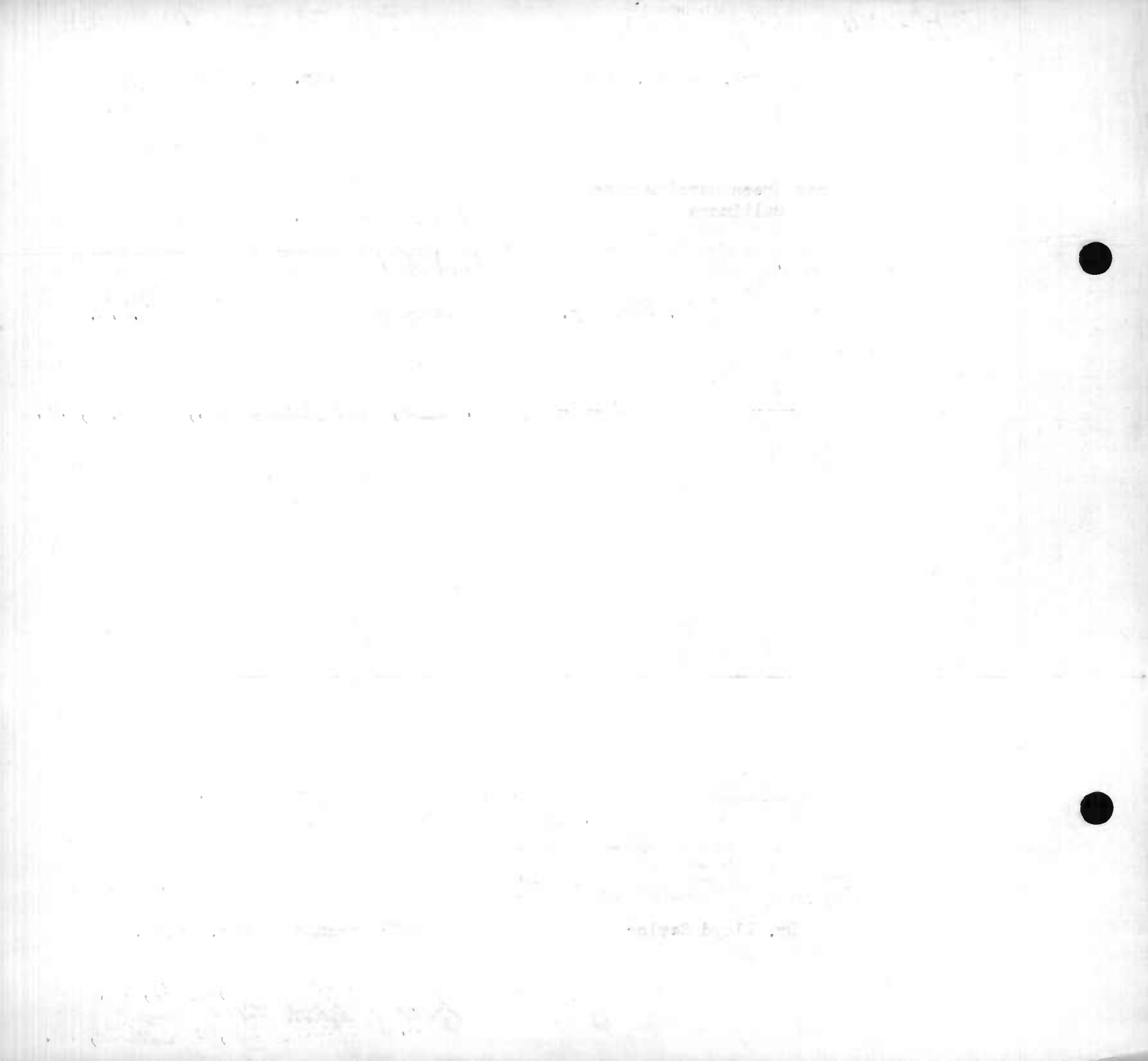
70 00980		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 00980	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>PASQUALE CELOZZI</u>				1-24-1970 6 <sup>20</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  37 MERCY HOSPITAL				A. STATE Md.		B. COUNTY 2608	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3501 GOUCH ST. #24							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-94	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Grocer		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MATTHEW CELOZZI				14. MOTHER'S MAIDEN NAME UNK.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 319-32-2059		17. INFORMANT ADDRESS Mrs. Palma Celozzi, same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Right sided hemiplegia pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-15-1970 to 1-24-1970 that (I) <del>was</del> last saw the deceased alive on 1-24-1970 and that (in my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.							
23A. SIGNATURE H. Makipour				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Houshang Makipour	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/28/70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore Md.				25A. DATE REC'D BY HEALTH DEPT. JAN 27 1970		25B. NAME OF REGISTRAR R. E. Jones, M.D.	
25C. FUNERAL DIRECTOR Joseph M. Zannone				25D. ADDRESS 2635 Conkling			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00981	
H-214 70 00981		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs. Belle E. Husfelt		Jan. 21, 1970 2:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Long Green Nursing Home Baltimore			Maryland Baltimore City 2706		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2601 Gibbons Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
Female	Can.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/24/1881	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Book Keeper		Wil. Trust Co.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Husfelt		Frances Bramble		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		213-48-5463		B. Veach, 2601 Gibbons Ave., Baltimore, Md.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
ANTECEDENT CAUSES			Arteriosclerotic cardiovascular disease 10 yrs.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 19 66 to Jan. 21 19 70, that (I) (we) last saw the deceased alive on Jan. 14, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lloyd E. Saylor				Jan. 22, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Lloyd Saylor				3902 Greenmount Ave. Balto.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				Asbury Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 28 1970		R. E. Taylor, Md.		Lee A. Patterson & Son, Perryville, Md.	

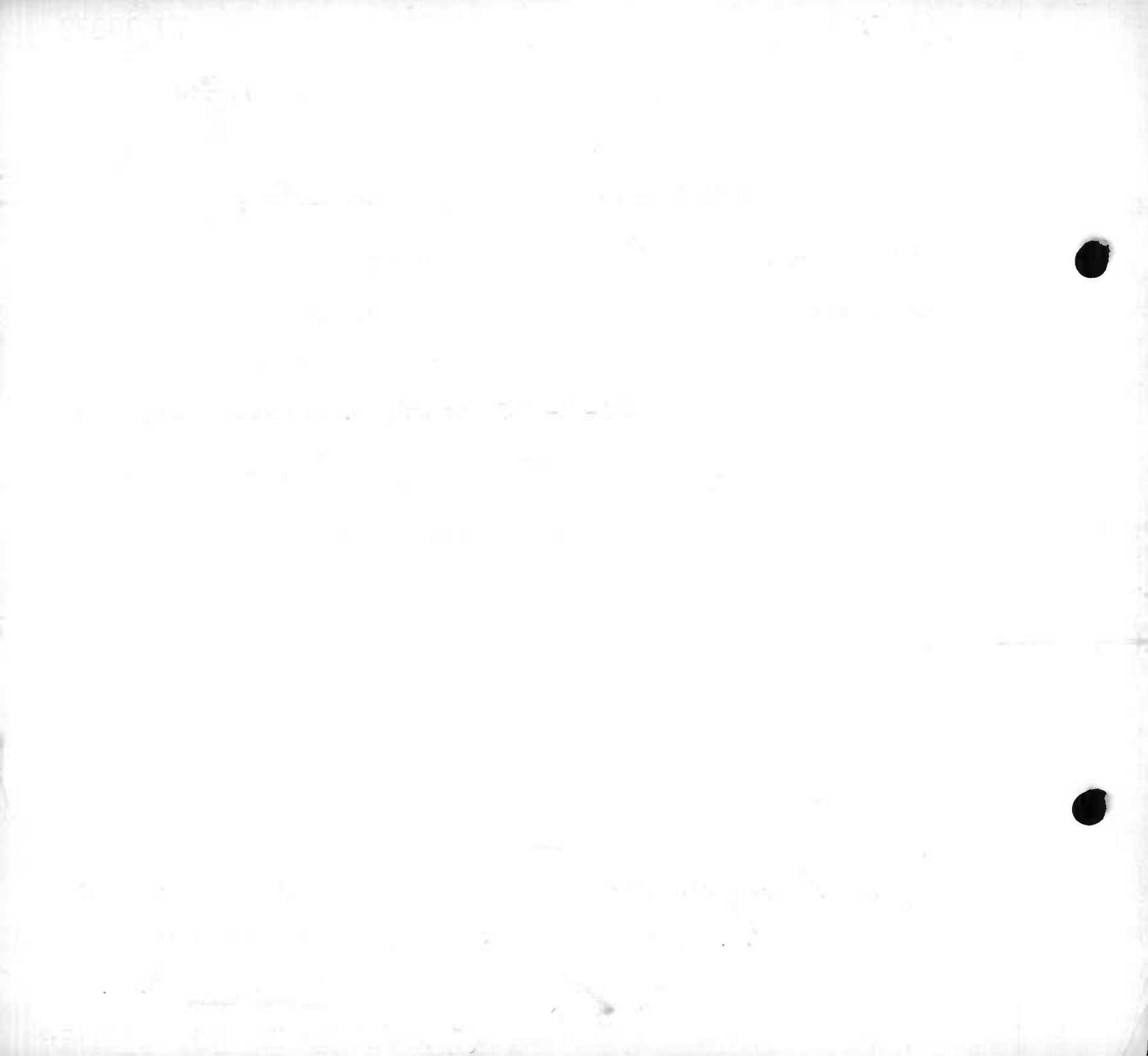




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-523		70 00982		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00982	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JONAS D. LANGSTON</b>				2. DATE AND HOUR OF DEATH <b>1/24/70 11:00 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Calvert Co 54-00</b>				M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>CHESAPEAKE BEACH</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>BOX # 7 STAR ROUTE 1</b>									
5. SEX <b>M</b>	6. RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-95</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ARETAS LANGSTON</b>				14. MOTHER'S MAIDEN NAME <b>MYTIA WILLIAMS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-01-8053</b>				17. INFORMANT <b>Mrs Ruby D. Langston</b>	
18. <b>185X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>? GRAM NEGATIVE SEPSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF PROSTATE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 yrs</b>					
MEDICAL CERTIFICATION				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (This hospital) attended the deceased from <b>JAN 13</b> 19 <b>70</b> to <b>JAN 24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>JAN 24</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>B. F. Hughes, M.D.</b>				23B. DATE SIGNED <b>1/24/70</b>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1/28/70</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cem/</b>	
24D. LOCATION (City, town, or county) (State) <b>Wilson, N. C.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>				25B. NAME OF REGISTRAR <b>2222 362 28</b>	
25C. FUNERAL DIRECTOR <b>Hutchins Funeral Home</b>				25D. ADDRESS <b>Owings, Md</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

S-165		70 00983		BALTIMORE CITY HEALTH DEPARTMENT		70 00983	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) William F. Springfield, Jr.				2. DATE AND HOUR OF DEATH January 23, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 Saint Agnes' Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 66F Wall Drive			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 9, 1924	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10B. KIND OF BUSINESS OR INDUSTRY City Sanitation Dept. Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William F. Springfield				14. MOTHER'S MAIDEN NAME Margie Ecton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes N/A				16. SOCIAL SECURITY NO. 217-12-7829		17. INFORMANT Viola Springfield Box 66F Wall Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.9 I Disease of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/28 1969 to 1/23 1970, that (I) (we) last saw the deceased alive on 12/12 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Karl F. Mech, M.D.				23B. DATE SIGNED 1/23/70		23C. PHYSICIAN'S NAME (Type) Karl F. Mech, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/26/70		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION Baltimore City, Maryland				24E. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker Sts.			

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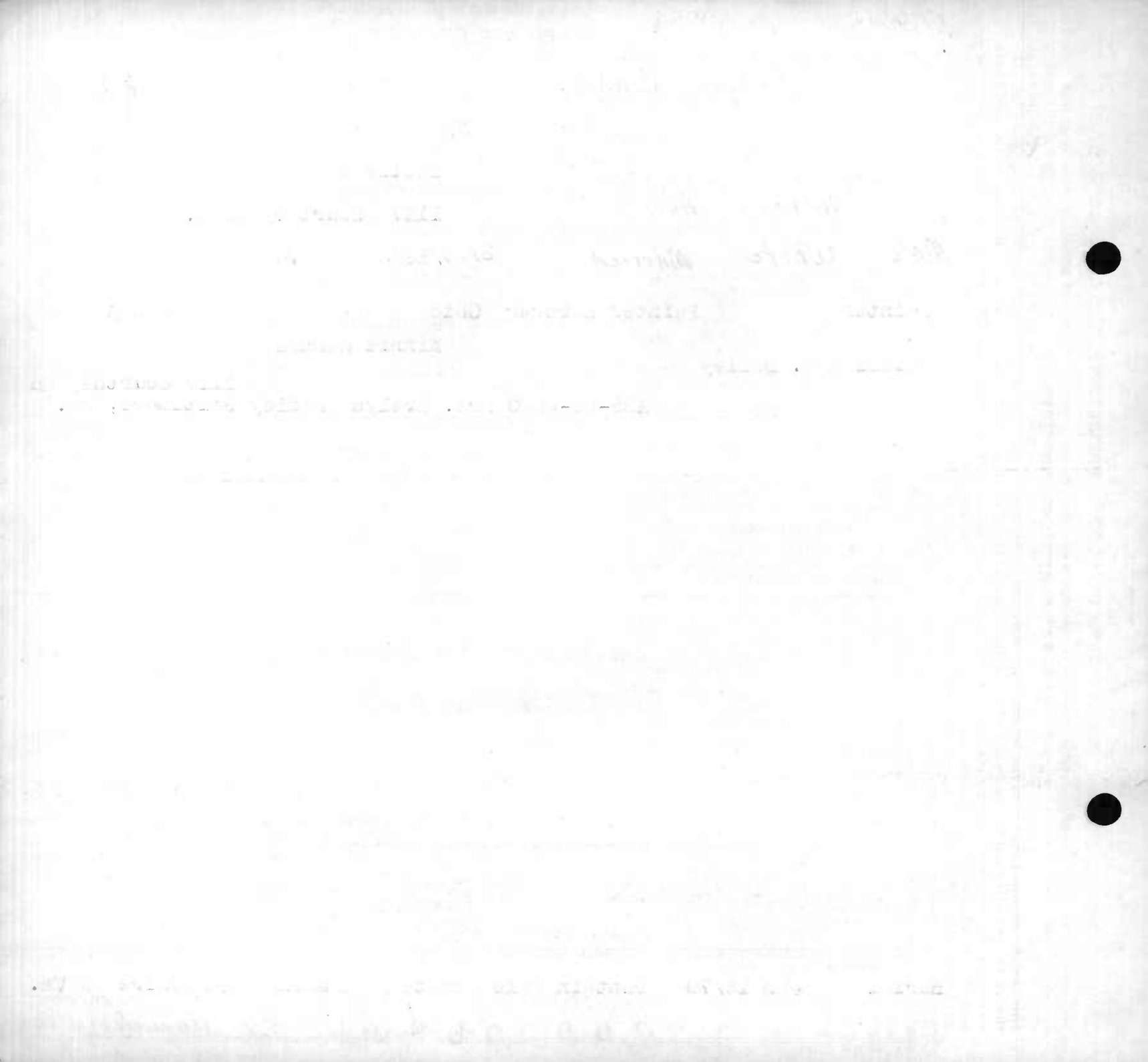
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 70 00984		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No. 70 00984	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Ralph Bailey	
2. DATE AND HOUR OF DEATH		JAN. 12, 1970 6:05 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		Md. Balto. Co. 5300			
St. Agnes Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
40 Wilkens Ave.		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1127 Courtney Road.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
Male	White	Married	8/30/1895	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Painter		Painter Laborer		Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William W. Bailey		Minnie Hannas		U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		235-32-6930		Mrs. Evelyn Bailey Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cirrhosis of the liver		17 years.	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 28, 1952 to March 29, 1963, that (I) (we) last saw the deceased alive on March 29, 1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Gilbert E. Rudman				1/13/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GILBERT E. RUDMAN		2517 W. BALTIMORE ST.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Jan 15/70		Mountain Dale Cemetery Shanks Hampshire W Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 28 1970		Robert E. Jackson, Md.		Wade H. McKee Augusta, W Va.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00985	
G-630 70 00985		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ALVIN E. GROTHE		1/22/70		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
710 W. 33rd. St.		Md.		C. CITY OR TOWN	
710 W. 33rd. St.		Balto.		D. INSIDE CITY LIMITS?	
710 W. 33rd. St.		710 W. 33rd. St.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/28/08	61	Maintenance man
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Md.				?	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
?		no		218-0507698	
17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
Margaret M. Grothe 710 W. 33rd St.		Arteriosclerotic Heart Disease unlk		20A. AUTOPSY? (Yes or No)	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		(B) Systemic hypertension unlk			
		(C) Diabetes Mellitus unlk			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		23A. SIGNATURE		23B. DATE SIGNED	
that (I) (we) lost saw the deceased alive on		James J. McPhillips MD		1/23/70	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
		James J. McPhillips		2 E. Read Street Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/26/70		Lakeview	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Balto. Co.		JAN 28 1970		Robert E. Feltz MD	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
Paul E. Chenoweth		3617 Chestnut Ave.		0 0 0 0 0 0 0 0	

*[Handwritten notes:]*

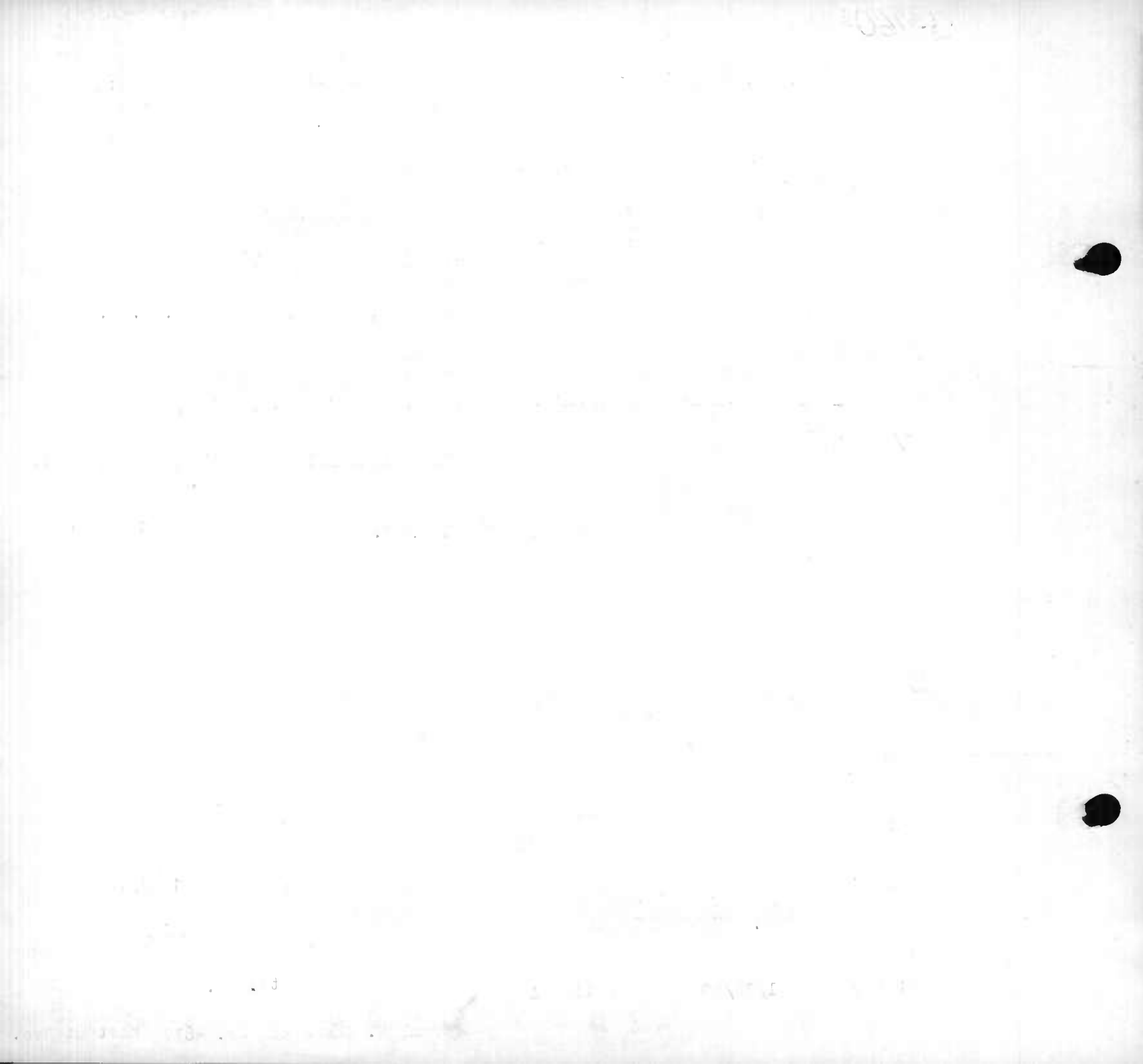
10/25/19  
Pd [unclear] 291-1117-1117-1117



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

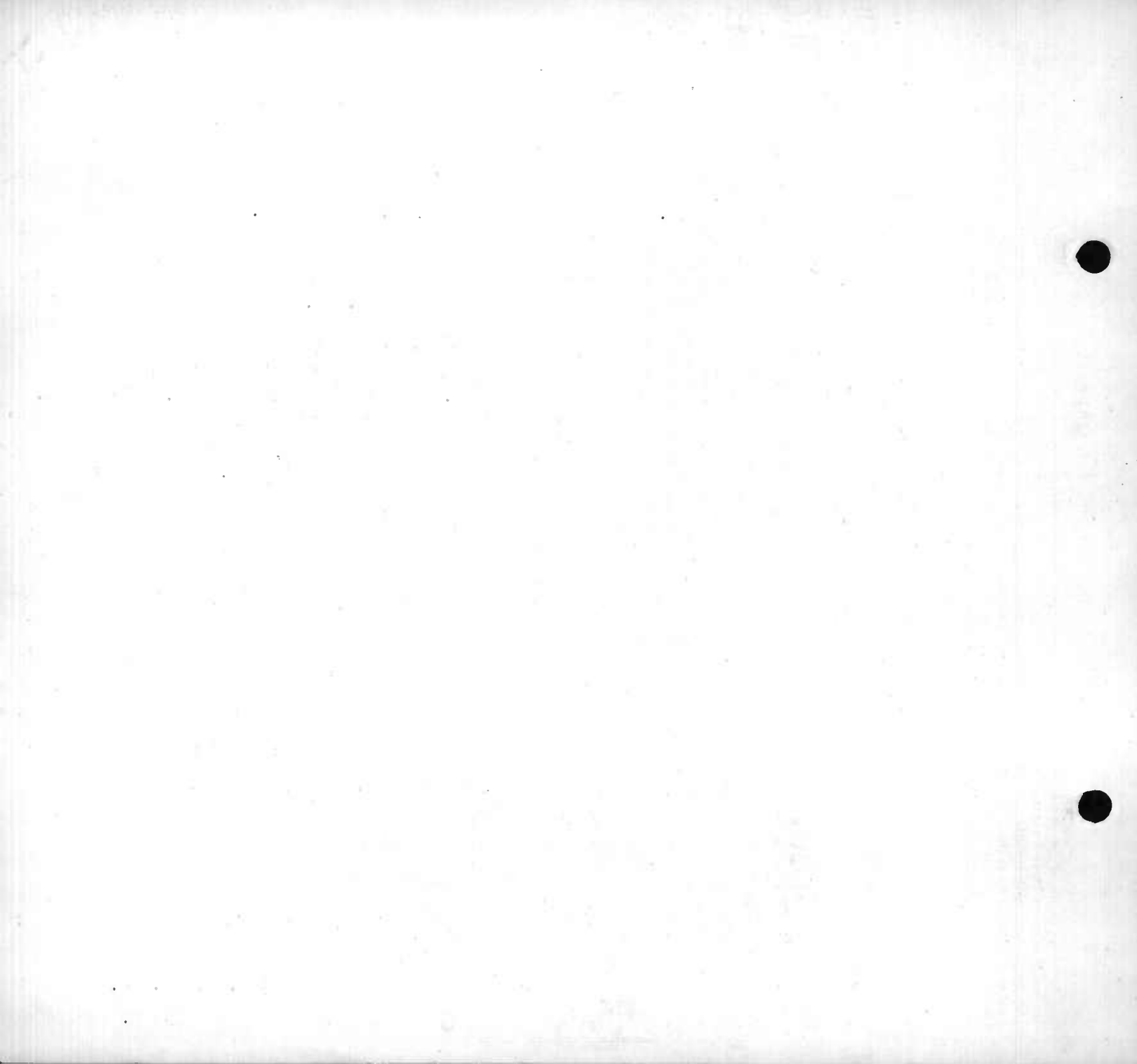
C-160 70 00986		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00986	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) COOPER, John MI		2. DATE AND HOUR OF DEATH 1-24-70 12:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		1207	
FULL NAME OF HOSPITAL OR INSTITUTION 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUCASION		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-19-93		9. AGE (In years last birthday) 76		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME DANIEL C COOPER		14. MOTHER'S MAIDEN NAME CATHERINE GRIFFEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6-10-15 TO 6-2-19		16. SOCIAL SECURITY NO. 218-09-64-64		17. INFORMANT VA HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTO, MD 21218	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. (B) GANGREN E LEFT LEG. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many Years 1 MONTH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 21 JANUARY 19 70 to 24 JANUARY 19 70, that (X) (we) last saw the deceased alive on 24 JANUARY 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 1/24/70		23C. PHYSICIAN'S NAME (Type) CARL E. BREIDENBERG MD	
23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/70		24C. NAME OF CEMETERY or CREMATORY National	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1970		25B. NAME OF REGISTRAR Paul E. Chenoweth Jr.		25C. FUNERAL DIRECTOR'S ADDRESS 3617 Chestnut Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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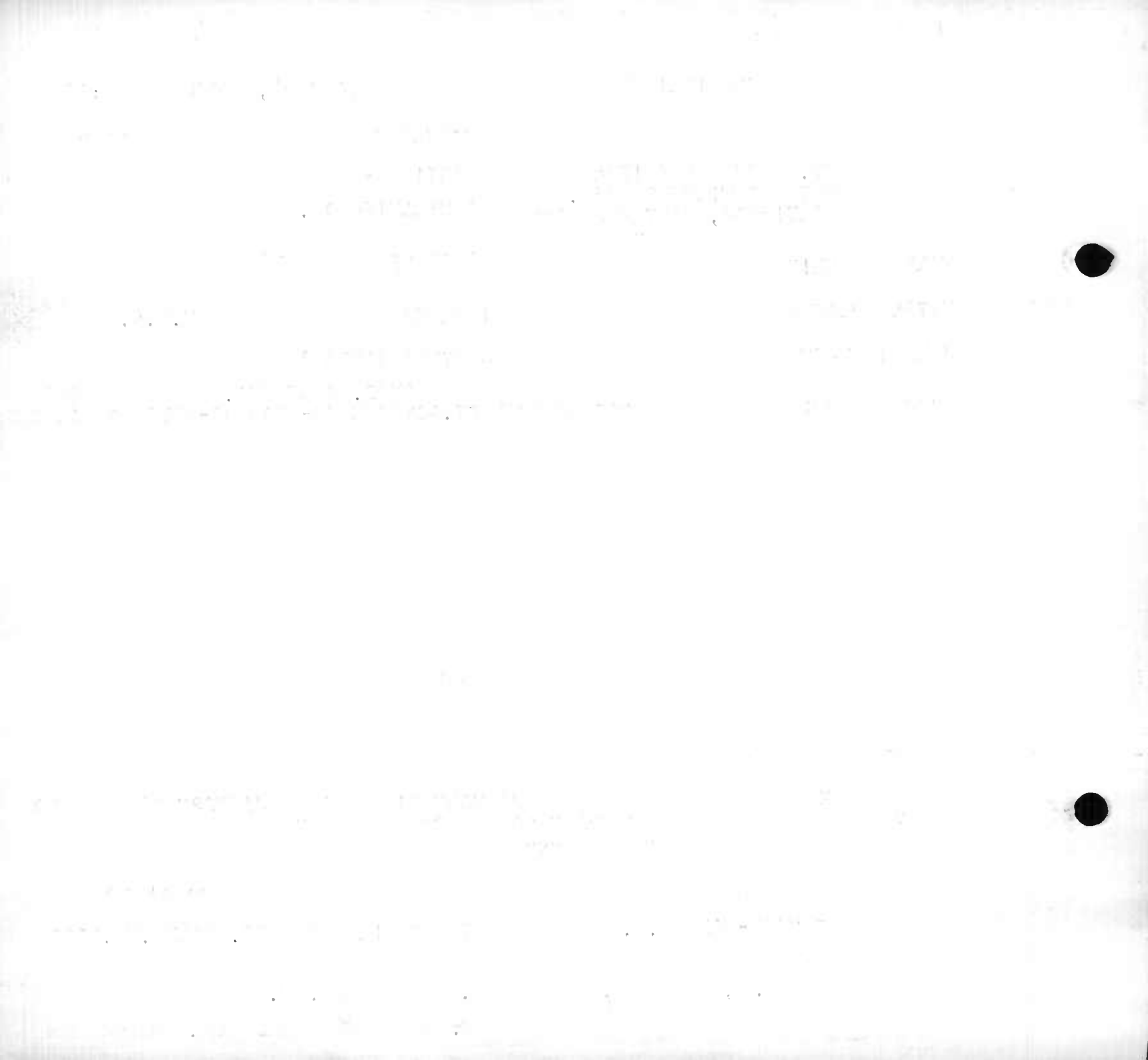
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00987
<b>B-240</b> <b>70 00987</b> <b>CERTIFICATE OF DEATH</b>		<b>1. NAME OF DECEASED</b> (Type or Print) <i>Blanche N. Bosley</i>		
<b>2. DATE AND HOUR OF DEATH</b> <i>1-24-70 1 800 A.M.</i>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION: <i>43 South Balto Gen. Hospital</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE: <i>Maryland</i> B. COUNTY: <i>2303</i>		<b>5. CITY OR TOWN</b> <i>Baltimore</i> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>7. STREET AND NUMBER</b> <i>1720 S. Charles St.</i>		<b>8. DATE OF BIRTH</b> <i>5 9 1894</i>		
<b>9. AGE</b> (In years lost birthday) <i>75</i>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <i>U S A</i>		
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Balto. Md.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U S A</i>		
<b>13. FATHER'S NAME</b> <i>Charles Hahn</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Laura Barnett</i>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> 		
<b>17. INFORMANT</b> <i>Mrs. Margaret Wright</i>		<b>ADDRESS</b> <i>1720 S. Charles St.</i>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Acute Myocardial Infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 		
<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>21. DATE OF OPERATION</b> <i>0</i>		<b>22. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>24. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>25. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				
<b>26. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>27. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>28. HOW DID INJURY OCCUR?</b>				
<b>29. I certify that (I) (this hospital) attended the deceased from</b> <i>June 6 1969</i> <b>to</b> <i>1/24/70</i> <b>19</b>				
<b>30. that (I) (we) last saw the deceased alive on</b> <i>1/22/70</i> <b>19</b>		<b>31. and that in (my) (our) opinion death occurred on the date</b>		
<b>32. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>33. SIGNATURE</b> <i>[Signature]</i>		<b>34. DATE SIGNED</b> <i>1/24/70</i>		
<b>35. PHYSICIAN'S NAME</b> (Type) <i>J. L. LOZANIK</i>		<b>36. ADDRESS</b> <i>1228 S. Charles St. Balt. Md. 21225</i>		
<b>37. BURIAL CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>38. DATE</b> <i>1 28 70</i>		
<b>39. NAME OF CEMETERY or CREMATORY</b> <i>Cedar Hill</i>		<b>40. LOCATION</b> (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>		
<b>41. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 29 1970</i>		<b>42. NAME OF REGISTRAR</b> <i>[Signature]</i>		
<b>43. FUNERAL DIRECTOR</b> <i>Mc Cully</i>		<b>44. ADDRESS</b> <i>130 E. Fort Ave</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-620</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00988</u>			
1. NAME OF DECEASED (Type or Print) <u>DARRAGH WILLIAM</u>				2. DATE AND HOUR OF DEATH <u>JANUARY 24, 1970</u> <u>1:15PM</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u> <u>CATON &amp; WILKENS AVES.</u> <u>BALTIMORE, MARYLAND 21229</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3 HILLVIEW DR.</u>							
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04 12 93</u>	9. AGE (in years last birthday) <u>76</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL POLISHER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>							
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN DARRAGH</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA (ADAMSON)</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW1</u>				16. SOCIAL SECURITY NO. <u>015 03 7067</u>							
17. INFORMANT <u>AVES. BALTO MD.</u>				ADDRESS <u>21229 ST. AGNES HOSP-RECORDS-CATON &amp; WILKENS</u>							
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Diabetese mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20A. AUTOPSY? (Yes or No) <u>NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)							
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 21</u> 19 <u>70</u> to <u>JANUARY 24</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>JANUARY 24</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Zaheer Kahn</u>				23B. DATE SIGNED <u>01 24 70</u>							
23C. PHYSICIAN'S NAME (Type) <u>ZAHEER-KAHN M.D.</u>				23D. ADDRESS <u>CATON &amp; WILKENS AVES. BALTO. MD. 21229</u>							
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan. 28, 1970</u>							
24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Kahn</u>							
25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>				ADDRESS <u>5151 Balto. National Pike</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				70 00989	
F-420				70 00989	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>MRS ANNA FLACK</b>			2. DATE AND HOUR OF DEATH <b>1/23/70</b> <b>9 20</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b> <b>2025 W. FAYETTE ST.</b> <b>BALTIMORE, MD 21223</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>2005</b>		
C. CITY OR TOWN <b>BALTO.</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>436 S. FURROW ST. BALTO. MD. 21223</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/05/80</b>	9. AGE (in years last birthday) <b>89</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>RIGBY</b>			14. MOTHER'S MAIDEN NAME <b>-</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>BALTO. MD.</b> <b>Mrs. Dorothy A. Reed</b>			ADDRESS <b>407 S. FURROW ST.</b>		
18. <b>269.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>DEHYDRATION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MALNUTRITION</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DEHYDRATION</b> (B) <b>MALNUTRITION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>?</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> 19 <b>70</b> to <b>1/23</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>1/23</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Orathai Thirawat</b> M.D. DEGREE				23B. DATE SIGNED <b>1/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT</b> M.D. DEGREE				23D. ADDRESS <b>BON SECOURS HOSPITAL, BALTO., MD 21223</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>JAN 27, 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LOUGEN PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>G. TRUMAN Schwab</b> ADDRESS <b>3512 Fred. Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 00990		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00990	
1. NAME OF DECEASED (Type or Print) <u>Johnson, Teresa C.</u>		2. DATE AND HOUR OF DEATH <u>1-25-70</u> <u>17</u> <u>48</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Howard</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		C. CITY OR TOWN <u>Ellicott City</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>5616 Montgomery Rd 6300</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-19</u>	9. AGE (in years last birthday) <u>50</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Paul Weiler</u>		14. MOTHER'S MAIDEN NAME <u>BR. Idget AA Noonan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. LEROY JOHNSON</u>	
				ADDRESS <u>5616 MONTGOMERY RD.</u>	
18. <u>410.01</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Myocardial Infarct</u>		<u>hours</u>	
		(C) <u>Hypertension</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN 20</u> 19 <u>70</u> to <u>Jan 25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-25-</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Agustin del Campo MD</u>				23B. DATE SIGNED <u>Jan. 25 70</u>	
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN de CAMPO</u>		23D. ADDRESS <u>Bon Secours Hosp. Balt. MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>RAYMOND L. KACIOROWSKI</u>			
		ADDRESS <u>2325 FLEET ST.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 00991	
70 00991				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Edward Majewski</u>		2. DATE AND HOUR OF DEATH <u>1-23-70</u> <u>11:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <u>00513 S. Wolfe St.</u>			A. STATE <u>Maryland</u>		B. COUNTY <u>203</u>
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>513 S. Wolfe Street-21231</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-19-92</u>	9. AGE (In years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>James Lacy Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Frank Majewski</u>		
14. MOTHER'S MAIDEN NAME <u>Stella Kozlaszewski</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-09-7071</u>			17. INFORMANT ADDRESS <u>Tillie Majewski- 513 S. Wolfe St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-23-70</u>		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <u>Arteriosclerotic C.V. Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>None</u>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 11</u> 19 <u>69</u> to <u>Jan 23</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>Jan 23</u> 19 <u>70</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. A. Schimunek M.D.</u>				23B. DATE SIGNED <u>1-24-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>EMMANUEL A SCHIMUNEK MD</u>				23D. ADDRESS <u>Raymond L. Kaczorowski-2525 Fleet St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-28-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Weber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Raymond L. Kaczorowski-2525 Fleet St.</u>			

213 2 Woltz St.

Male white

1-14-22 78

Frank Majewski  
James and Polak  
Stella Kojanowski

No. 213 2 Woltz St. - 213 2 Woltz St.

Report to Kozlowski - 213 2 Woltz St.  
Barnard 1-22-22 Holy Rosary Con. Baltimore, Md.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be proved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

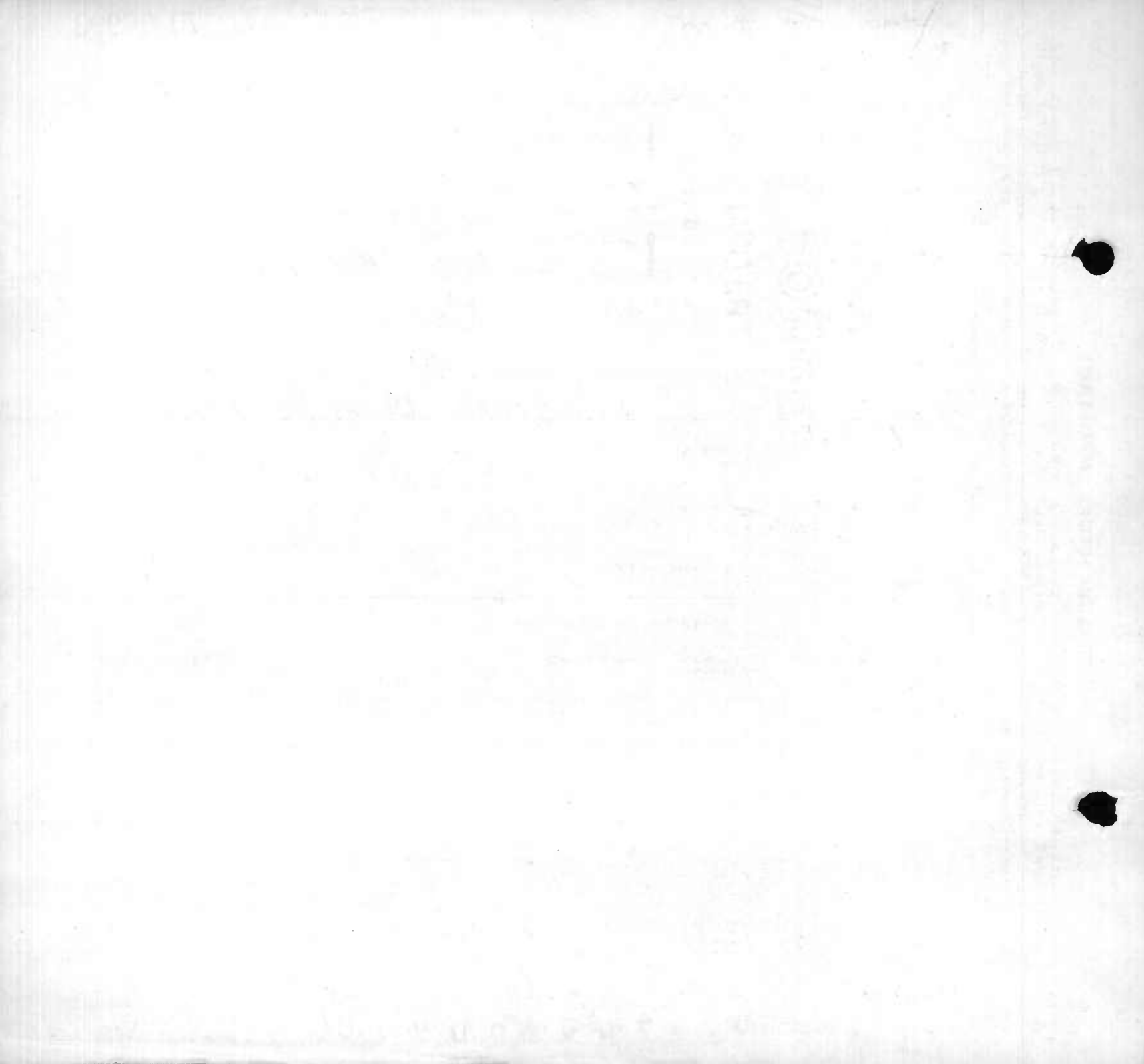
BIRTH NO. 70 00992				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00992	
1. NAME OF DECEASED (Type or Print) <b>MARGARET HARTMAN</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 21 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>104</b>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>816 S. MILTON AVE. 00 BALTIMORE MD.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 4, 1881</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <b>88</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-54-0928</b>		17. INFORMANT <b>Miss CECILIA HARTMAN</b>		ADDRESS <b>816 S. MILTON AVE.</b>	
18. <b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anger's offail failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic vascular disease</b>				(B) <b>Arteriosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>Arteriosclerotic</b> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1 1967</b> to <b>Jan - 22 19 70</b> , that (I) (we) last saw the deceased alive on <b>Jan - 21 - 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William G. Geyer M.D.</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>WILLIAM G. GEYER</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 23/1970</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. CARMEL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>ANDRZEJ KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-3001		70 00993		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00993	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Thomas Sult</i>			
2. DATE AND HOUR OF DEATH <i>JANUARY 19 1970</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>104</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 CHURCH HOME AND HOSPITAL</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2700 HUDSON ST.</i>							
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 28 1894</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CRANE OPERATOR</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>A. SARCO</i>		11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>UNKNOWN</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>212-10-1727</i>		17. INFORMANT <i>MRS. BERTHA SULT</i>		ADDRESS <i>2700 HUDSON ST.</i>
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CANCER OF LUNG</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 YRS</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/27</i> 19 <i>55</i> to <i>1/4</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>1/4</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Benjamin H. H. Stein M.D.</i>				23B. DATE SIGNED <i>1/21/70</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>BENJAMIN HILHSTEIN M.D.</i>				23D. ADDRESS <i>1212 HIGHLAND BALTIMORE MD 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>JAN. 23 1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>ST. STANISLAUS CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1970</i>		25B. NAME OF REGISTRAR <i>Robert J. Kobayashi</i>		25C. FUNERAL DIRECTOR <i>RAYMOND OKACZKOWSKI</i>		ADDRESS <i>2525 FLEET ST.</i>	





# FUNERAL DIRECTOR: IMPORTANT

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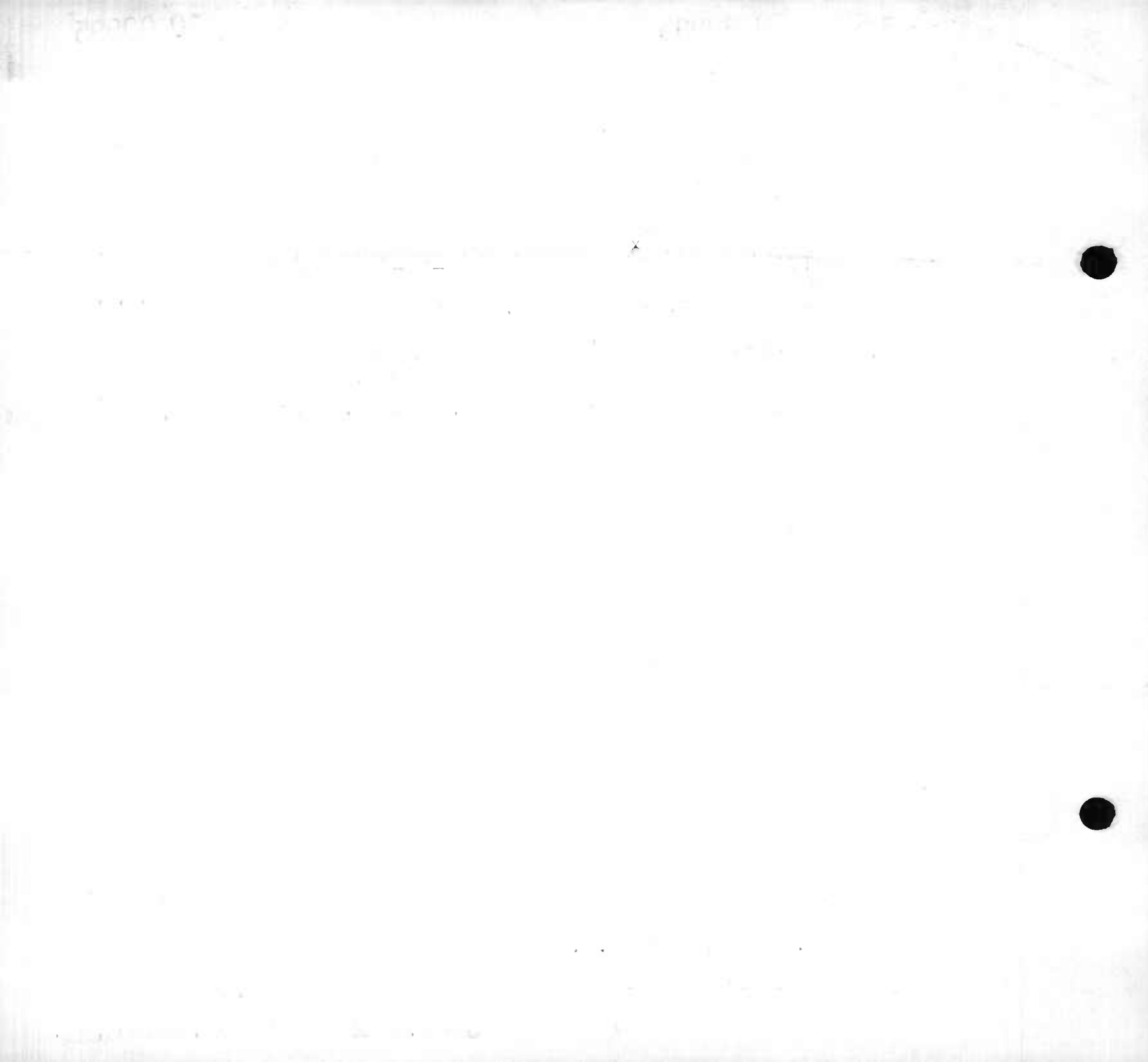
P-260		70 00994		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 00994	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAROLD P. PACKER</b>				2. DATE AND HOUR OF DEATH <b>JAN 25, 1970 12 Noon</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>53-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 16, 1905</b>		9. AGE (In years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Bernard</b>				14. MOTHER'S MAIDEN NAME <b>Rose</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>219-42-6137</b>		17. INFORMANT <b>Mrs Bernice Parker</b>		ADDRESS <b>Same</b>			
18. <b>410.9 I</b>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial infarction minutes</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Known arteriosclerotic heart disease 12 years</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec. 19 68</b> to <b>Jan 25 19 70</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>in Dec. 19 69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.									
23A. SIGNATURE <b>Louis H Schaffer MD</b>				23B. DATE SIGNED <b>1/26/70</b>					
23C. PHYSICIAN'S NAME (Type) <b>Louis H Schaffer, MD</b>				23D. ADDRESS <b>222 W Cold Spring Lane, Baltimore, MD 21202</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balta Helms</b>		24D. LOCATION (City, town, or county) (State) <b>Reisterstown Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Stephen J. Lewis &amp; Son</b>		ADDRESS <b>9610 Reisterstown Rd</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

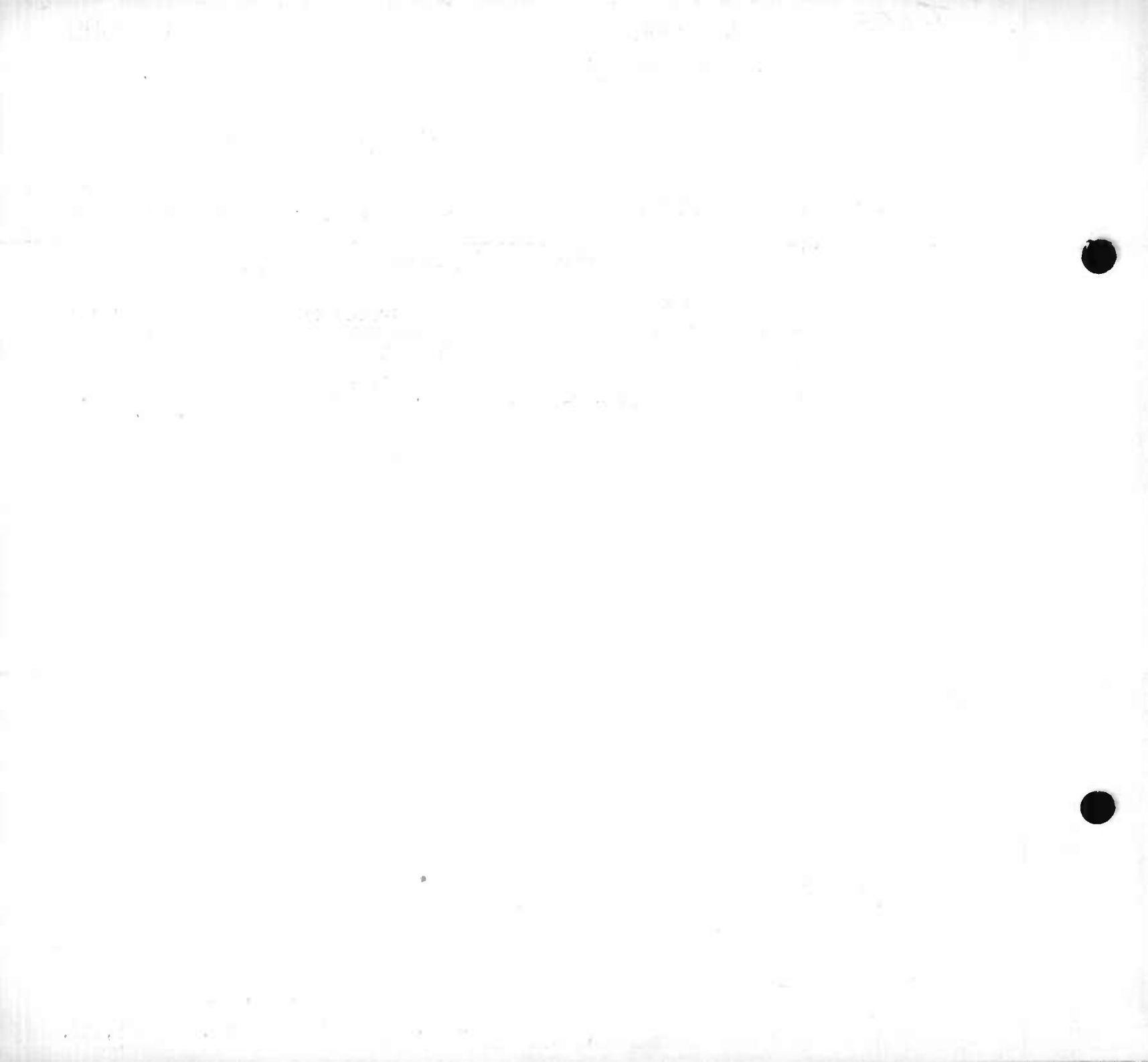
<div style="display: flex; justify-content: space-between;"> <span>S-357</span> <span>70 00995</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO. -02-</span> <span>70 00995</span> </div>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MAURICE C. STUMPF</b> <b>MAURICE STUMPF</b>		2. DATE AND HOUR OF DEATH <b>1/24/70</b> <b>12:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b> <b>33</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> <b>53-00</b>		C. CITY OR TOWN <b>Dundalk</b> <b>BALTIMORE</b>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>07-02-10</b>		9. AGE (In years last birthday) <b>59</b>		10. UNDER 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Globe Security Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RICHARD STUMPF</b>		14. MOTHER'S MAIDEN NAME <b>SARAH LEWIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>214-01-4400</b>		17. INFORMANT <b>Wife:</b> <b>Mrs. Bertha B. Stumpf</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) <b>Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 day</b>		(C) <b>Brainstem stroke (CVA)</b> <b>3 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 20</b> 19 <b>70</b> to <b>JAN 24</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>JAN 24</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. Greg Brown M.D.</b>		23B. DATE SIGNED <b>1/24/70</b>		23C. PHYSICIAN'S NAME (Type) <b>B. GREG BROWN M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		25E. ADDRESS <b>21222</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 00996</u>	
T-653		70 00996		70 00996	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>NICHOLAS TRIANTAFILOS</u>		2. DATE AND HOUR OF DEATH <u>1-23-70</u> <u>3:05</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GEN. HOSPITAL</u> <u>Maryland General Hospital</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>2108 LINCOLN AVE</u>		<u>21219</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-92</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tavern Owner</u>		11. BIRTHPLACE (State or foreign country) <u>GREECE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN TRIANTAFILOS</u>		14. MOTHER'S MAIDEN NAME <u>MARIA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-07-3969-A</u>		17. INFORMANT <u>Wife:</u> <u>Mary F. Triantafilos</u> <u>2108 Lincoln Ave.</u> <u>Baltimore, Md. 21219</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>2 days</u>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> 19 <u>70</u> to <u>1-23</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>1-23</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Angelita A. Topacio</u>		23B. DATE SIGNED <u>1-23-70</u>		23C. PHYSICIAN'S NAME (Type) <u>ANGELITTA A. TOPACIO</u>	
23D. ADDRESS <u>MARYLAND GEN. HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-27-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> <u>7922 Wise Ave. Dundalk, Md.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE W. RAGLAND</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 24, 1970 7:10 A.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1101</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>August 23, 1910</b>		10. AGE (In years last birthday) <b>59</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF <b>U.S.</b>	E. STREET AND NUMBER <b>909 N. Calvert Street 21202</b>
13. FATHER'S NAME <b>Henry Ragland</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
15. MOTHER'S MAIDEN NAME <b>Alice ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W 2</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Alice A. Ragland</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive pulmonary thrombo-embolism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cranio-cerebral Injuries</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Cirrhosis of the liver</b>		ADDRESS <b>21202 909 N. Calvert St.</b>	
20A. DATE OF OPERATION <b>21</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Kinsey's Esso Station</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Balto. and Hilton Streets</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12-29-69 Unk. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject fell while at work</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/25/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/28/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Yeager, M.D.</b>	25C. FUNERAL DIRECTOR <b>McCubley &amp; H</b>	ADDRESS <b>237 Patapsco Ave. 21225</b>

78800 00

STATE OF NEW YORK

78800 00

IN SENATE,

JANUARY 1, 1900.

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1899.

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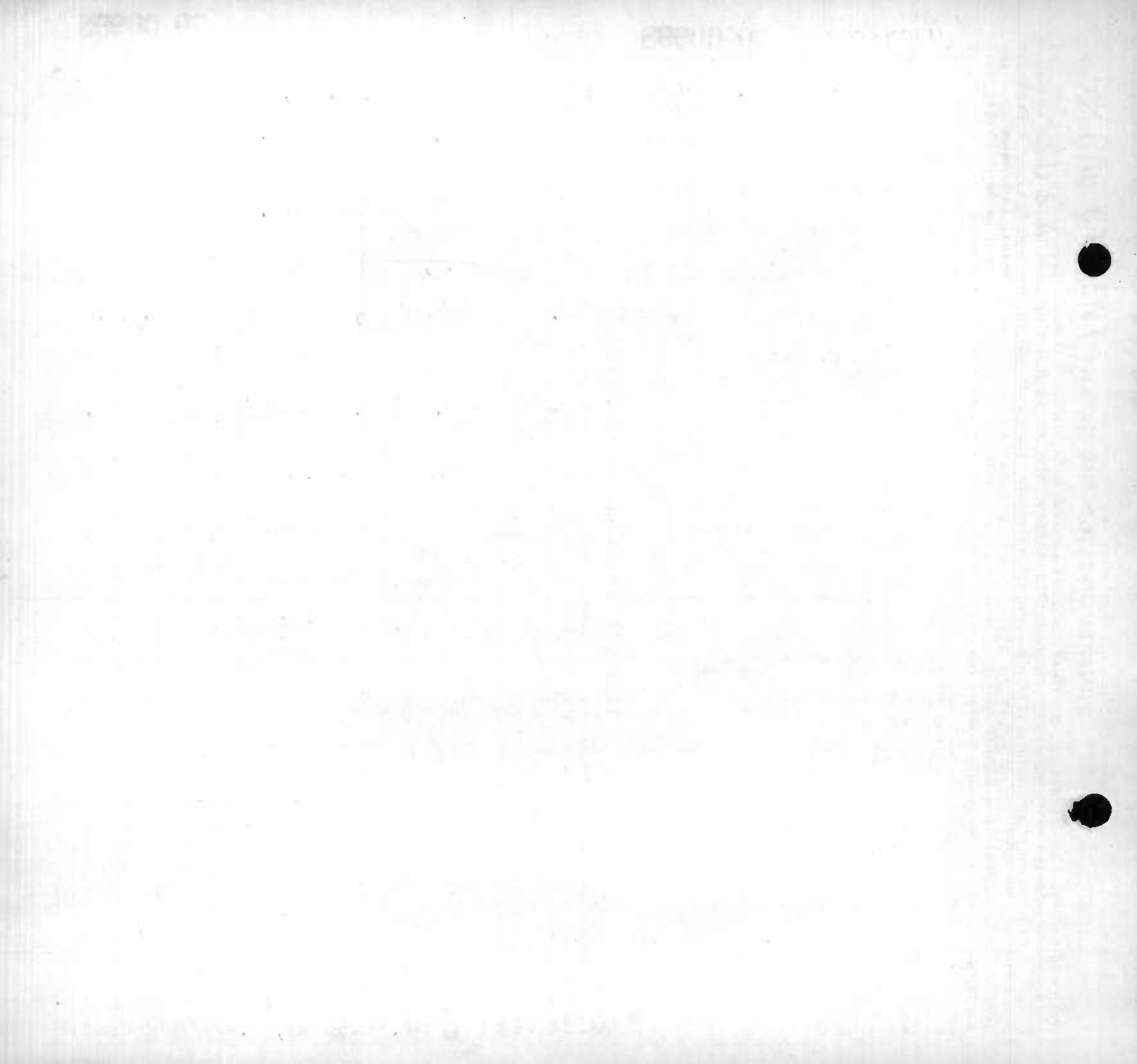
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# FUNERAL DIRECTOR: IMPORTANT

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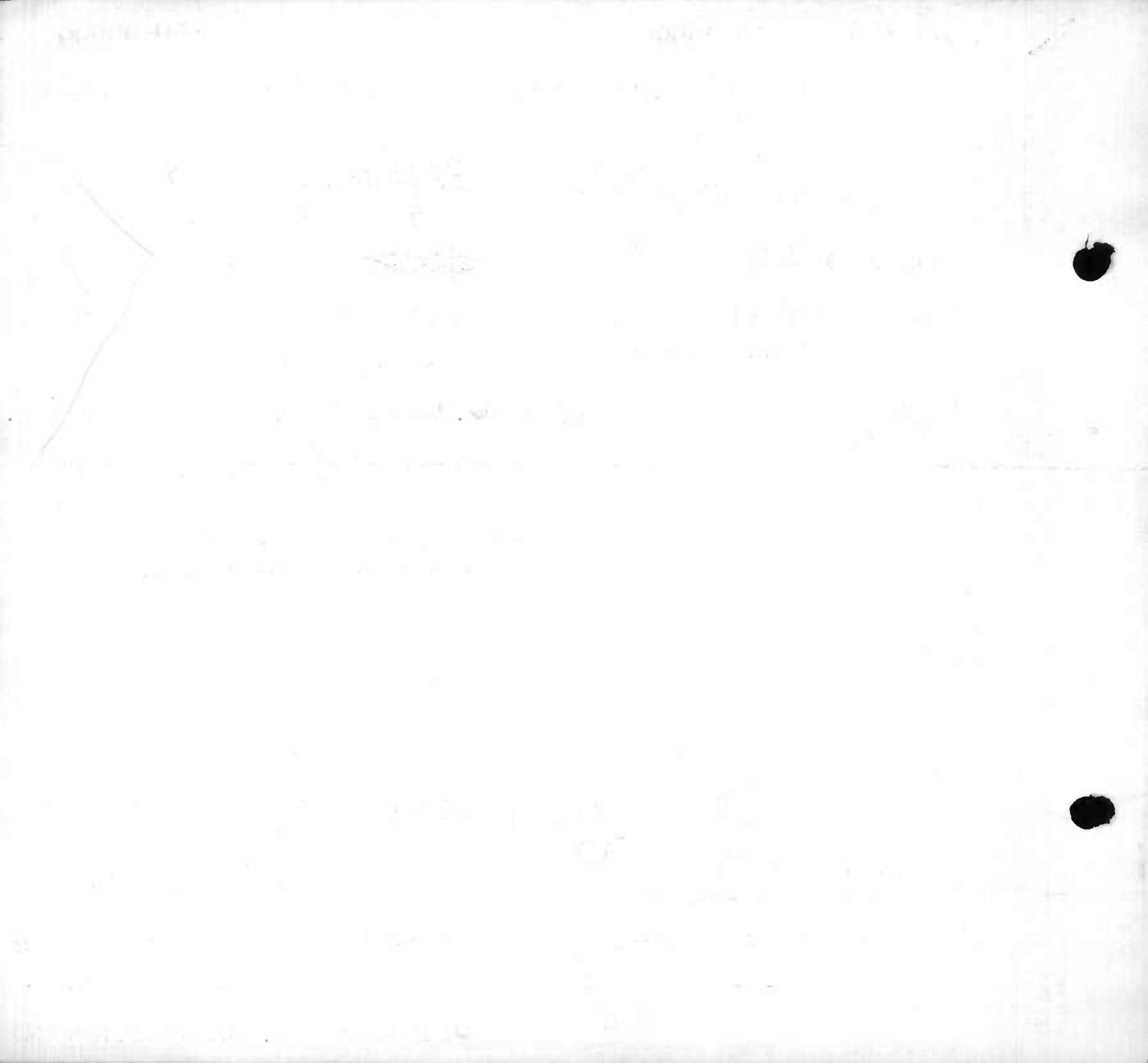
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 00998</b>	
<b>M-420</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Delmas A. Mills</i>		<b>70 00998</b> <b>CERTIFICATE OF DEATH</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Anderson Nursing Home</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>Jan. 25, 1970</i> <i>7 P.</i> M. <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Woodlawn</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>2031 Russell Ave.</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. RACE</b> <i>White</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>Jan. 8, 1907</i>	<b>9. AGE</b> (In years last birthday) <i>63</i>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Time Keeper</i>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Time Keeper</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Calvert Dist.</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Toddsville, Maryland</i>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>
<b>13. FATHER'S NAME</b> <i>John O. Mills</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>?</i>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		<b>16. SOCIAL SECURITY NO.</b> <i>212-05-2258</i>		<b>17. INFORMANT</b> <i>Mrs. Lula B. Mills</i>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Broncho-pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arterio-sclerotic Heart Disease</i> (C) <i>Parkinson's Disease</i>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>5 days</i> <i>3 yrs.</i> <i>5 yrs.</i>			
<b>19. DATE OF OPERATION</b> <i>4/12/31</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>Generalized Arterio-sclerosis</i>		<b>20A. AUTOPSY?</b> (Yes or No) <i>No</i>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <input type="checkbox"/>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>July 9, 1968</i> <b>to</b> <i>JANUARY 25, 1970</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>JAN 24, 1970</i> <b>and that in (my) (our) opinion death occurred on the date</b> <i>JAN 25, 1970</i> <b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Earl L. Chambers, M.D.</i>				<b>23B. DATE SIGNED</b> <i>JAN 27-1970</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>EARL L. CHAMBERS M.D.</i>				<b>23D. ADDRESS</b> <i>100 W. Cold Spring Lane BALTIMORE MD.</i>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>1/28/70</i>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Woodlawn</i>	
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Woodlawn, Baltimore, Md.</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 28 1970</i>			
<b>25B. NAME OF REGISTRAR</b> <i>John T. Starbury, Sr.</i>		<b>25C. FUNERAL DIRECTOR</b> <i>John T. Starbury, Sr.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460		70 00999		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 00999	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>LOUIS MILLER</b>			
2. DATE AND HOUR OF DEATH <b>1/21/70 10.20 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2740</b>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>			
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>5908 CROSS COUNTRY BLVD.</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/1911</b>	9. AGE (in years last birthday) <b>74</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor Retired Ladies Ready Wear</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Miller</b>				14. MOTHER'S MAIDEN NAME <b>Eva Epstein</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>215-01-7956</b>		17. INFORMANT <b>Mrs. Beatrice Miller, 5908 Cross Country Blvd.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt;24hrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/21/1970</b> to <b>1/21/1970</b> that (I) (we) last saw the deceased alive on <b>1/21/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Peter Papastamoy</b>				23B. DATE SIGNED <b>1/21/70</b>		23C. PHYSICIAN'S NAME (Type) <b>PETER PAPASTAMOY</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-23-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>	
24D. LOCATION (City, town, or county) (State) <b>BERRYMAN'S LANE, REISTERSTOWN, MD.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>			
25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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L-260				70 01000		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 01000	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">A. <b>ALVIN LESSER</b></div>				2. DATE AND HOUR OF DEATH <b>FRIDAY, JANUARY 23, 1970 8:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">42 SINAI HOSPITAL</div>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2730</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6728 WESTBROOK ROAD #15</b>					
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>62</b>		9. AGE (In years lost birth day) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>DANVILLE, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL LESSER</b>				14. MOTHER'S MAIDEN NAME <b>ETHEL ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>126-18-9418</b>		17. INFORMANT ADDRESS <b>Mrs. Rhoda Lesser, 6728 Westbrook Road #15</b>			
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Probable Acute Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerotic Hypertension or disease (Acute MI May 1969)</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>10 years</b> <b>2 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>Unexplained Anemia</b> <b>Heart</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>21 August 1969</b> to <b>6 January 1970</b> , that (I) (we) last saw the deceased alive on <b>7 January 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Abraham Genechin M.D.</b> DEGREE						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>23 Jan 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM GENECHIN</b> DEGREE						23D. ADDRESS <b>611 PARK AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-25-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BETH TIFLOH</b>		24D. LOCATION (City, town, or county) (State) <b>WINDSOR MILL ROAD, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert H. [unclear]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD.</b>					

